FRAMEWORK FOR STATE EVALUATION OF CHILDREN'S HEALTH INSURANCE PLANS UNDER TITLE XXI OF THE SOCIAL SECURITY ACT

(Developed by States, for States to meet requirements under Section 2108(b) of the Social Security Act)

State/Territory: Colorado
(Name of State/Territory)

The following State Evaluation is submitted in compliance with Title XXI of the Social Security Act (Section 2108(b)).

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(Signature of Agency Head)

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DEFINITIONS OF TERMS USED IN THIS REPORT

AFDC	Aid to Families with Dependent Children
The Alliance	Colorado's Health Care Coverage Cooperative
AND	Aid to the Needy Disabled
CBGH	Colorado Business Group on Health
CBHP	Children's Basic Health Plan (state term for Colorado's S-CHIP)
CCHP	Colorado Child Health Plan (Colorado's S-CHIP predecessor)
CDHCPF	Colorado Department of Health Care Policy and Financing (also referred to as HCPF)
CHP+	Child Health Plan Plus (official name for Colorado's S-CHIP)
CHPRS	Colorado Health Plan of the Rockies
CICP	Colorado Indigent Care Program
CPS	Current Population Survey, from the March Supplement, U.S. Census Bureau
CUHIP	Colorado Uninsurable Health Insurance Plan
The Department	Refers to the Colorado Department of Health Care Policy and Financing
DSS	Department of Social Services
EPSDT	Early and Periodic Screening, Diagnosis and Treatment (Preventive health care program for Medicaid clients up to age 21)
FEHBP	Federal Employees Health Benefit Plan
FFY	Federal fiscal year (October 1-September 30)
FPL	Federal Poverty Level
FQHC	Federally Qualified Health Centers
FRM	Free and Reduced Price lunch program offered through the schools' National School Lunch Program
HCFA	Health Care Financing Administration
HCP	Colorado's Children with Special Needs program
HEDIS	Health Plan Employer Data and Information Set
HHS	Health and Human Services
HMO	Health Management Organizations
IPA	Individual (Independent) Practice Association
LA RASA	Latin American Research and Service Agency
MCH	Maternal Child Health program
OAP	Old Age Pension
Policy Board	Colorado's Children's Basic Health Plan Policy Board (also called "The Board")
PPO	Preferred Provider Organization
The Program	Refers to Colorado's S-CHIP, Child Health Plan Plus, or CHP+
RFP	Request for Proposal

SED	Satellite Eligibility Determination site (sites around the state trained to provide outreach for CHP+ and to determine eligibility for enrollment)
SFY	State fiscal year (July 1-June30)
SSI	Social Security Income
The State	[when capitalized] decisions and practices in Colorado determined outside the authority of the Department or the CHP+ program
TANF	Temporary Assistance to Needy Families
WIC	Women, Infants, and Children

STATE OF COLORADO
S-CHIP EVALUATION
EXECUTIVE SUMMARY

March 1, 2000

BACKGROUND

Colorado's Children's Basic Health Plan (also known as Child Health Plan Plus or CHP+) provides subsidized health insurance coverage for low-income children. Eligible children are under 19 years of age, are part of a family earning up to 185% of the Federal Poverty Level (FPL) and are not eligible for Medicaid. Families with gross family incomes above 100% of the FPL pay a state-subsidized monthly premium for covered benefits. The benefits include primary and preventive health care, prescriptions, hospital services, glasses and hearing aids and mental health services.

This program is supported by the new Title XXI program of the Social Security Act (P.L. 105-100). The Federal legislation, enacted under the Balanced Budget Act passed by Congress in August 1997, provides authority and funding to states to expand health care coverage for uninsured children. It also gives states considerable discretion to design a program to meet their particular needs. Options included expanding Medicaid, developing a state-designed program, or developing a combination of these two options for different age or family income brackets. Colorado elected a state-designed program.

The program is administered by the Colorado Department of Health Care Policy and Financing (CDHCPF, also called HCPF, or "the Department"), in the Office of Program Development, and is directed by the Children's Basic Health Plan Policy Board. The eleven-member Policy Board was established by statute and charged with promulgating program rules. The Board also provides a public forum for discussion of major policy issues, offers policy direction to the Department, and provides program oversight. Under the current legislative authority, the Board will sunset in July 2000. Legislation to continue the Policy Board is pending.

The Colorado Department of Health Care Policy and Financing is the state agency responsible for developing and implementing financing plans and policy for publicly funded health care programs. It administers Colorado's major publicly funded health care programs (including Medicaid and the Colorado Indigent Care Program).

In 1992, the University of Colorado Health Sciences Center operated a State-financed program called the Colorado Child Health Plan (CCHP). This program was designed to provide outpatient services to low-income, uninsured children in the state. In 1997, the Colorado General Assembly passed HB 97-1304 that established a new program, the Children's Basic Health Plan (CBHP), to be marketed as Child Health Plan Plus (CHP+), to provide comprehensive health insurance to children in families with incomes up to 185% of the federal poverty level. The CHP+ program was therefore designed to replace the CCHP program.

The legislation authorizing CHP+ was supported by a diverse coalition of business leaders, child advocates, health plans and providers, physicians, corporate and community-based providers, charitable foundations and government agencies. It had broad-based support because of the recognized benefits of providing access to health services to children in Colorado.

The General Assembly later modified the CHP+ program to conform to the unique opportunity presented by the new, federally funded Title XXI program. Colorado's existing publicly-subsidized child health program infrastructure, and the rapid response to the opportunity, made the state a national leader in expanding health care coverage to low-income children. Colorado, in fact, was the first state in the country to have a non-Medicaid-expansion S-CHIP plan approved by the Health Care Financing Administration (HCFA).

ACCOMPLISHMENTS

Although the current program is fairly new, there have been many accomplishments over the past year. These accomplishments include:

- Achieved statewide coverage;
- Finalized service contracts with HMOs;
- Developed a State-managed network to cover areas of the state where there was no risk-based managed care contract available;
- Put in place data systems that are now producing data valuable to program monitoring;
- Established and implemented a performance-based contracting system for the privatized components of program administration and development;
- Streamlined the application process;
- Reduced the amount of time needed to process applications;
- Improved coordination with the Colorado Departments of Human Services and Public Health and Environment, with the Division of Insurance, the Colorado Uninsurable Health Insurance Program, and many other State and local public- and private-sector partners;
- Developed an equitable capitation rate and risk-sharing model for HMOs; and,
- Developed and implemented public communications and input processes.

There are a series of key issues that the CHP+ program continues to face. Some are specific to Colorado. Others, however, the State considers to be of general interest and may require national attention. Colorado strongly recommends that Congress and DHHS continue to recognize the developmental nature of this program and the need for strong long-term commitment from policy makers on doing business in new and innovative ways. This evaluation process will help states meet the goal of insuring every eligible child if it focuses on best practices and disseminating that information nationally to all S-CHIP programs.

1. Federal/State Relationships

   Colorado chose to utilize a non-Medicaid expansion program. This was done based on careful reading of the legislation, conversations with local and national experts and a consistency with local mores. The Governor's and the legislature's understanding of the Federal enabling legislation was that the intent of S-CHIP was to encourage states to try different models to address the lack of health insurance for certain low-income populations. It appears HCFA has favored a Medicaid expansion and has interpreted statutes in a way that favors Medicaid models, especially for the population under 100 percent of poverty.

   Colorado has chosen to utilize a commercial model for S-CHIP because it reflects the traditional workplace model. It assists families in understanding the private health care market as they move from public assistance to the work force. In addition, it provides equity between children acquiring health insurance through S-CHIP and those whose parents have access to health insurance in the work place.

   Because Colorado is relatively small and has chosen not to expand the Medicaid infrastructure, the 10-percent limit on Federal funding for S-CHIP administrative costs represents a significant barrier to implementation and growth of the program**. S-CHIP in Colorado is essentially an individual health insurance program.** The State has the burden of one-time start-up expenses and marketing individually to each of the approximately 70,000 eligible children. In the business environment, the federal tax codes recognize start-up and capital costs and have a method to amortize start-up costs. This program was expected to start up with an operational budget that placed limits on the program's ability to cover the traditional start-up costs (i.e., space, information systems, equipment, and training), but with high expectations for enrollment totals. The individual health insurance market, where it exists, has been marked by exceedingly high administrative costs, indicating the difficulty in direct marketing, high participant turnover, and higher-than-average medical experiences. Little consideration was given to these issues in implementing the program nationally.

   Colorado strongly urges Congress to re-evaluate the 10-percent administrative cap and
   1. remove marketing and outreach from that limitation, and
   2. provide some "safety valve" for legitimate, one-time, start-up costs.

2. Ability to Enroll Underserved/Working Populations

This program, as stated above, is essentially an individual health insurance program for populations who have traditionally been both outside the parameters of the safety net and not able to access the commercial market. Nationally, there has been an expectation that eligible families would flock to this program. Over 18 months, Colorado has learned a great deal about enrolling the children of low-income working families in a voluntary health insurance program.

a. Many families in this income range have learned how to access the safety net for needed acute services for their children.
b. Insurance emphasizes long-term risk prevention. For families who feel they have little to risk, the economic consequences of not having insurance may not make sense. Families make economically expedient choices.
c. Most children are healthy. Colorado's experience is that eligible families with the youngest children and the highest (proportionately) income are most likely to enroll in the program.
d. Continuing, intensive outreach programs generally reach families already "in the system;" e.g., through safety net providers or community-based organizations. The State has yet to learn how to reach families outside of the mainstream, or those who are working and therefore assume that they are not eligible for government programs. In a recent survey undertaken in Colorado, a common reason parents gave for not enrolling was that they thought they were not eligible.

3. Access Versus Cost: Development of a Consistent Policy Approach

The CHP+ program has demonstrated unprecedented bipartisan and public/private support. There is widespread understanding of the benefits of providing access to health care for children and the resulting societal benefit of a healthy populace. In the development of program policy, two major issues have arisen in this implementation year. The first is improving access to care. The second, developing a cost-effective program using state-of-the-art management techniques.

Many program issues have been debated by policy makers and the community within the context of the seemingly contradictory concerns of improving access and operating in a limited budget environment.

Improving Access

Colorado has chosen to develop a state-only, non-Medicaid program that mirrors the commercial model. However, there is recognition by policy makers that this is a program for children who have often been left out of the mainstream and whose families may need assistance negotiating the system. Issues regarding adequate access to services are:

a. Designing a benefit package that addresses the anticipated needs of low-income

children, without modeling it on Medicaid;

b. Maintaining a statewide health care delivery system for children that is adequate in a state that has wide disparities in the general health care system;
c. Developing operating rules that clearly define this program as separate from Medicaid, are easy for families to understand, and meet federal requirements.

Cost-Effective Programming

The second competing theme related to program costs and expenditures has been maintaining the required funds for the state match. However, cost is also considered in terms of cost sharing to the families through premiums and coinsurance.

Colorado is the only state in the country with tax and spending limitations. This puts an enormous burden on the State to find resources to support needed programs, including those with enhanced federal matching reimbursement. Each decision made by the program has to be balanced by the ability of the State to provide match funds in a budget that is pressured by a variety of local needs.

4. Family Cost Sharing

There are several objectives that can be accomplished by requiring families to pay a premium for CBHP participation. They are:

1. Reduce health care spending by the State;
2. Instill a sense of ownership in participants for their health care;
3. Minimize the stigma associated with welfare programs;
4. Reduce the potential for families to discontinue private health insurance in favor of a government program; and
5. Serve as a bridge between Medicaid, which is free, and private insurance, which is considerably more costly.

The program in Colorado also has been developed with a recognition of the following two precepts:

- Premium levels should not significantly deter families from purchasing health insurance on behalf of their children; and
- Premiums should be imposed in a cost-effective manner.

The Colorado legislature has stated clearly that premium payments are not intended to raise revenue for primary financing for the program. Rather they primarily are designed to instill a sense of value for the health care services received and to prepare eligible clients for the private insurance cost-sharing requirements.

The debate around family cost sharing through premiums (not copayments) by policy makers has focused both on the appropriate level of premiums and the impact of premiums on enrollment. The discussion is exacerbated by the lack of reliable data on either subject. The vast differences in S-CHIP

program design across states limits the value of cross-state experiences. Colorado would welcome empirical studies that focus on enrollment impact or practical options around premium levels. HCFA's discouragement of family cost sharing has not been helpful for states with a legislative commitment to maintain family cost sharing as an integral program component. There has been limited dialogue on this subject between HCFA and states. A more open and positive relationship might allow for both useful research and creative problem solving to occur.

5. Employer-Based Coverage

While it is likely that many CHP+-eligible children may have access to employer-based coverage, that coverage may be unaffordable. It is also true that, in Colorado, as in most states, Title XXI has not reached all eligible children using non-employer-based marketing strategies. During the first year of operation, marketing and outreach strategies focused on families accessing community-based organizations, including safety net providers. In the second full year of operation, CHP+ will attempt to reach other targeted populations, including those with at least one employed parent.

Given the potential availability of employer-based insurance, coupled with an unreached population, Colorado officials have begun to consider the feasibility of a Title XXI Premium Assistance program. Under such a program, CHP+ funds would be leveraged into employer-based coverage when it is available, rather than enrolling children directly in the "regular" CHP+. Advantages to this approach include:

1) covering more children by creating an alternate means by which families can gain access to CHP+;
2) maximizing state and federal funds by taking advantage of employer contributions where available;
3) utilizing existing private coverage to keep families together under a single insurance plan;
4) minimizing the potential stigma associated with "public" health insurance programs; and,
5) minimizing "crowd out" of coverage.

Finding: Given existing federal regulations, Colorado does not believe that implementing this program will be feasible. The Department strongly recommends that HCFA reevaluate its approach to Premium Assistance programs to encourage states to work with employers who currently provide some limited coverage to their employees, which does not meet the high standards proposed in the revised federal regulations for CHIP programs.

6. Program Structure

A significant concern has been the question "What is the correct administrative structure for this program?" The following quotes are excerpts from an evaluation of the administration of the program which was undertaken by the CBHP Policy Board in September, 1999, under the direction of the legislature *(For full report, see Attachment P: Report on Administrative*

Structure of the CHP+ Program in Colorado, by RK Associates):

"This report acknowledges that the CHP+ program in Colorado is successful, evolving and improving. It should be noted, however, that a number of challenges still exist. . .

"**Focus** – As a new program, many things needed to occur simultaneously. Central among these was the development of rules under which the program would operate. The Board determined that it needed extensive public input in the formulation of such rules. That process has been underway for some time, and the first series of rules is about to be published. *[Note: As of September1999, no rules had been passed, but since then, one rule has passed and three additional ones are pending.]*

"Unfortunately, the time needed to complete these steps has frustrated and concerned many of the program's supporters. This, in large part, results from insufficient staff available to support and direct this process at the level necessary.

"**Partnership Concept** - The reference to 'public-private partnership' has been used extensively in the description of this program. That may not be an apt reference, however, in that the way it has played out is much more like the traditional state contractor arrangement. It is also a concept that would benefit from definition since many respondents applied their own different interpretation to the concept.

"The processes for developing contracts and implementing the program need to be addressed to avoid the frustrating delays associated with the state's procurement process. However, the Board or the DHCPF [sic] cannot address this alone. It will require the involvement and commitment of other state agencies, and should be addressed in the larger context of creating a framework for developing a 'public-private partnership.'

"**Goal Setting** – The program did not meet all respondents' expectations. In many ways, this is because the varied constituencies have differing, unstated goals ranging from number of enrollees, impact on health status, establishment of rules and promotion of interagency coordination. Further, the legislation is not clear regarding how the success of the program will be measured. In a very practical way, then, the goals for the program have never been delineated clearly. This lack of clarity has become the single greatest obstacle to the program's efficient and effective operation.

"**Coordination and Consolidation** – The legislation states inter-program coordination and consolidation as a goal of CHP+. It is a goal of the federal enabling legislation as well. Thus far, virtually no progress has

been made toward this goal, given other more pressing start-up challenges. This problem must be addressed directly and will require a substantial investment of staff time and commitment across the four affected agencies to reach a solution.

"**Resources** – The Board's lack of staff and budget has left it dependent on the DHCPF for the resources it has. While the Department has made some staff available, the resources simply are not adequate to support the start-up of a substantial new Program, especially one that requires a new way of thinking and doing business.

CONCLUSION:

"The implementation of CHP+ is well underway, despite limited resources and the challenges inherent in the nature of a public-private partnership. This program is of great interest to many people. It is important not only that the program be successful, but that it also be *perceived* to be successful and that policy makers give thoughtful consideration to charting the course. The success in implementation will make the difference in the lives of thousands of children. It is with this goal in mind that this report should be used as a guide for the future. It should also be understood that there necessarily will be different inputs and evaluations along the way. It will be important to assure that the key stakeholders reach consensus on achieving the goals according to an agreed upon timeframe. The Policy Board has determined that it will develop a two-year workplan, which will enable all constituencies to have a measurable set of objectives against which they can measure success."

SECTION 1. SUMMARY OF KEY ACCOMPLISHMENTS OF YOUR CHIP PROGRAM

This section is designed to highlight the key accomplishments of your CHIP program to date toward increasing the number of children with creditable health coverage (Section 2108(b)(1)(A)). This section also identifies strategic objectives, performance goals, and performance measures for the CHIP program(s), as well as progress and barriers toward meeting those goals. More detailed analysis of program effectiveness in reducing the number of uninsured low-income children is given in sections that follow.

1.1 What is the estimated baseline number of uncovered low-income children? Is this estimated baseline the same number submitted to HCFA in the 1998 annual report? If not, what estimate did you submit, and why is it different?

Colorado's S-CHIP estimated baseline of uncovered, low-income children is 172,457, with a CHIP-eligibles baseline estimate of 69,157. This is a revision since the estimate submitted to HCFA in the 1998 annual report. The Department felt the availability of more recent data, specific to Colorado, provided opportunity to derive an estimate that would more closely reflect the current status of children in the state.

1.1.1 What are the data source(s) and methodology used to make this estimate?

Colorado's S-CHIP began with year 2000 population projections for children under age 19 for each county in the state. The source of these projections was the Colorado Demography Information Service within the Colorado Division of Local Government. Then, using individual county uninsured rates (published in the 1997 Colorado Health Source Book: Insurance, Access, and Expenditures, April 1998, and funded by the Rose Community Foundation and The Colorado Trust), each county's population projection was multiplied by its uninsured rate to get the number of uninsured under age 19 in that county. The Colorado Health Source Book derived the method for determining its uninsured rates from "Estimating County Percentages of Uninsured People," Inquiry, 28:413-419 (1991), and used a three-year average of 1995-1996-1997 CPS data from the March Supplements. County uninsured rates ranged from 9.0% to 40.9% among the 63 counties in Colorado, varying widely from the overall state estimate of 15.2%. The computed county estimates of uninsured under age 19 were summed to get a total for the state. The following tables summarize this methodology:

Number of Children Who Are Uninsured

	Colorado 1997 County Uninsured rates (Colorado Demography Information Service)	**2000 Colorado Population under Age 19**	**# of Uninsured under Age 19 (Sum of County Estimates)**

Uninsured under 19	Range = 9.0% - 40.9%	1,145,447	172,457

This represents all uninsured children in the state, at all income levels. To determine the number of children who would be S-CHIP-eligible, or at or below 185% of the federal poverty level (FPL), The Department used an estimate from the American Academy of Pediatrics (AAP) which says that S-CHIP-eligibles under 200% FPL in the state comprise 40.1% of the uninsured under age 19. The source for this estimate was AAP's analysis of 1994-1997 March Current Population Survey Supplements and a 1998 Census Bureau child population projection. Each county's under-19 uninsured estimate was multiplied by this percentage to ge difference is negligible, attributable to the rounding of county estimates.)

Number of Uninsured Children Who Are S-CHIP-Eligible:

	AAP CHIP-Eligible Percentage (Using 1994-1997 CPS and Census 1998 projection)	**Number of Uninsured under Age 19**	**2000 Colorado Population under Age 19, Uninsured, and under 200% FPL**
Uninsured under age 19	40.1%	172,457	69,157

It is this final estimate -- 69,157 -- against which Colorado's S-CHIP measures its performance in reducing the proportion of uncovered, low-income children in the state, for FFY 1998 and FFY 1999.

1.1.2 What is the State's assessment of the reliability of the baseline estimate? What are the limitations of the data or estimation methodology? (Please provide a numerical range or confidence intervals if available.)

The reliability of the Current Population Survey (CPS) data has long remained in question, and must be considered with caution for the following reasons:

1) CPS data are based on a very limited sample of households (only about 1,000 in Colorado), and not necessarily representative of Colorado's population demographics.
2) Surveys are conducted mostly by telephone, and the question of whether or not a person is uninsured is not asked directly; uninsured totals are rather a calculation of a residual.
3) The CPS tends to overestimate the uninsured, since information is collected at a single point in time, and may not reflect the child's actual situation over a year's time.
4) Year-to-year variations can occur producing wide margins of error, but these are reduced somewhat by use of a three-year average.

The Urban Institute believes the CPS undercounts the number of Medicaid enrollees who would be part of the uninsured count, thereby inflating S-CHIP-eligibles estimates. Colorado is looking at recent Urban Institute data for possible new strategies for estimating the uninsured. Additionally, the following limitations may be associated

with the methodology the State used:

1) Using 1997 uninsured rates for counties and applying them to projections for the year 2000 may assume rates that are no longer applicable in the projected year. They are the most recent county rates we have available, however, and are based on multiple years' CPS data to diminish the effects of inherent year-to-year variability.
2) Assuming whole-county uninsured rates apply to all age groups within the county can be problematic. Since we do not, however, have rates specific to age groups, Colorado feels this is the best estimate currently available.
3) As above, even by using county-specific data, total uninsured may include some children who are actually Medicaid-eligible, and not S-CHIP-eligible.
4) Applying a statewide percentage to each county, when counties may vary in their proportion of eligibles under 200% FPL.
5) This estimate would include children in the 185% - 200% FPL, exceeding Colorado's income eligibility requirement. The most recent data we have addressing this income range comes from the 1993 RAND Corporation Survey, funded by the Robert Wood Johnson Foundation, which estimated that 2.48% of the uninsured under 200% FPL may be above 185% FPL. Using the State's estimates, this would result in a subtraction of 1,715 children, or a total S-CHIP-eligibles of 67,422. Thus, our estimate *could be expressed as a range of 67,422 to 69,157*. Colorado has chosen, however, to use the higher end of this range until more accurate, up-to-date data becomes available for determining this small segment of the uninsured. Moreover, there are ongoing discussions for raising Colorado's income upper limit to 200%, which would eliminate the need to change the overall estimate.

   With new AAP estimates (just published), new population projections, Census 2000 data upcoming, and new methods for deriving more state-specific data, Colorado plans to update its uninsured estimate yearly, at the end of each federal fiscal year.

1.2 How much progress has been made in increasing the number of children with creditable health coverage (for example, changes in uninsured rates, Title XXI enrollment levels, estimates of children enrolled in Medicaid as a result of Title XXI outreach, anti-crowd-out efforts)? How many more children have creditable coverage following the implementation of Title XXI? (Section 2108(b)(1)(A))

The State Plan maintains that coverage through Colorado's S-CHIP will reduce the number of uninsured children by 50% *(See Table 1.3, Performance goal "a" for Strategic Objective #1,)*, or, with this year's estimate of S-CHIP-eligibles, from 69,157 to 34,579. *[It should be noted this goal is not tied to a specific year, so should not be confused with the yearly program goals that drive the budget.]* During FFY 1998, 14,847 *unduplicated* children had

been extended comprehensive health care coverage under Colorado's S-CHIP program, called Child Health Plus (CHP+). This is 21.5% of the State's estimated eligibles. At the end of FFY 1998, as of data run on December 8, 1999, Colorado's S-CHIP had extended coverage to 24,116 *unduplicated* children during FFY 1999. This is 34.9% of its baseline uninsured at or below 185% FPL. These totals include all children covered during each of those two federal fiscal years, *which would include some children who may have disenrolled or whose coverage was terminated*. Possible reasons for disenrollment/termination, many of which reflect naturally-occurring reasons a child becomes ineligible (aging out, higher income, available employer-based insurance, etc.), are covered in later sections of this report (see section 4.2.1).

Colorado's Title XXI year-end enrollment total, as of September 30, 1998, was 9,641, or 13.9% of the state's eligibles, after only five months of operation. As of September 30, 1999, enrollment totaled 21,289 children, which is 30.8% of the state's estimated eligibles. The Department considers this a noteworthy achievement in just over 17 months of program operation, significantly exceeding the expectation of 22% of Colorado's eligibles by the end of FFY 1999 which was established in 1998. This 1999 year-end total is over 400% of the enrollment that was in the program during its first month of operation. Though Colorado began its program in April, 1998, with 5,528 children who rolled over from the existing outpatient-only program (Colorado Child Health Plan, or CCHP), these children were not given comprehensive health care in CCHP, so would not qualify as having received creditable health insurance prior to Title XXI implementation.

Although some of the children now enrolled in CHP+ may have been eligible previously for other government programs such as CCHP or Colorado Indigent Care Program (CICP), these children also would not have had access to a comprehensive health insurance package. Also, children enrolling in Colorado's S-CHIP program cannot have had insurance for at least three months prior to application for the program. Given these two reasons, it can be assumed that the number of children with creditable health coverage has increased, since April 1998, by 21,289 children.

Colorado believes that some new Medicaid enrollees are participating as a result of S-CHIP outreach, and is initiating efforts to track this secondary effect of S-CHIP's efforts. The Department does not yet have a good estimate of these children because the data have not been routinely collected up to this point.

1.2.1 What are the data source(s) and methodology used to make this estimate?

Administrative data are the data source for S-CHIP enrollment counts; these data are managed by an eligibility and enrollment contractor, and reported monthly to the State. For an estimate of Medicaid enrollment due to S-CHIP outreach, Colorado will track applicants who originate with an S-CHIP application.

When the eligibility and enrollment contractor forwards an application to Medicaid, the

applicants are tracked in a database. A transmittal cover sheet is included with the application, along with a request for DSS to return it to the contractor once a Medicaid determination has been made. The returned transmittals are tracked in the same database, to identify which children being referred to Medicaid are enrolled, and which children are denied. All applications forwarded to Medicaid, resulting in an enrollment, can be attributed to Title XXI outreach, since the application was originally submitted to the S-CHIP program office, by either the family or a non-DSS SED site.

1.2.2 What is the State's assessment of the reliability of the estimate? What are the limitations of the data or estimation methodology? (Please provide a numerical range or confidence intervals if available.)

The methodology described in Section 1.2.1 may have the following limitations:

With the method described above, there is no guarantee that the cover sheet that goes with the application to DSS will be returned as requested. This is not a procedure that has been in practice in Colorado until now. The State believes, however, that in time this may become an effective, routine method for tracking the number of Medicaid-enrollees originating with the S-CHIP program office.

1.3 What progress has been made to achieve the State's strategic objectives and performance goals for its CHIP program(s)?

Please complete Table 1.3 to summarize your State's strategic objectives, performance goals, performance measures and progress towards meeting goals, as specified in the Title XXI State Plan. Be as specific and detailed as possible. Use additional pages as necessary. The table should be completed as follows:

Column 1: List the State's strategic objectives for the CHIP program, as specified in the State Plan.

Column 2: List the performance goals for each strategic objective.

Column 3: For each performance goal, indicate how performance is being measured, and progress towards meeting the goal. Specify data sources, methodology, and specific measurement approaches (e.g., numerator, denominator). Please attach additional narrative if necessary.

For each performance goal specified in Table 1.3, please provide additional narrative discussing how actual performance to date compares against performance goals. Please be as specific as possible concerning your findings to date. If performance goals have not been met, indicate the barriers or

constraints. The narrative also should discuss future performance measurement activities, including a projection of when additional data are likely to be available.

Table 1.3		
(1) Strategic Objectives (as specified in Title XXI State Plan)	(2) Performance Goals for each Strategic Objective	(3) Performance Measures and Progress (Specify data sources, methodology, numerators, denominators, etc.)
OBJECTIVES RELATED TO REDUCING THE NUMBER OF UNINSURED CHILDREN		

Table 1.3		
1. Decrease the proportion of children in Colorado who are uninsured and reduce the financial barriers to affordable health care coverage	1a) Decrease in the proportion of children ≤ 185% FPL who are uninsured by 50%	Data Sources: Under age 19 population estimates for 2000 by the Colorado Demography Information Service; county uninsured rates from 1997 Colorado Health Source Book, using 1995-97 CPS data; American Academy of Pediatrics' estimate of proportion of S-CHIP-eligibles in the under age 19 uninsured population (using 1994-1997 CPS data). Methodology: The program's baseline was calculated using the Colorado Demography Information Service's estimate of the under-19 population for each county in Colorado, for the year 2000 (based on historical data and estimates of population growth rate). Then county uninsured estimates from the 1997 Colorado Health Source Book (using an average of 1995-1997 CPS data) were applied to each county's projection. With AAP's estimate of the proportion of S-CHIP-eligibles among the uninsured (based on an average of 1994-1997 CPS data), 40.1% of the uninsured under age 19 were computed for each county, and summed for a state total. This resulted in 69,157 uninsured children under age 19 and eligible for S-CHIP. Numerator: (FFY 1998, year-end total) 9,641; (FFY 1999, year-end total) 21,289 Denominator: (FFY 1998) 69,157 est. eligibles; (FFY 1999) 69,157 est. eligibles Progress Summary: By the end of FFY 1998, comprehensive health care coverage was being given to 9,641 children who previously did not have access to affordable health insurance, or 13.9% of the estimated uninsured. It was estimated that by the end of FFY 1999, 22% of the previously uninsured would be covered. At FFY 1999's end, coverage was being given to 21,289 children, or 30.8% of previously uninsured children. This constitutes 61.6% of the State's goal of 50% of uninsured children at or below 185% FPL, in just over 17 months of operation.
OBJECTIVES RELATED TO CHIP ENROLLMENT		

Table 1.3		
	1b) Increase the percentage of uninsured children enrolled in the Children's Basic Health Plan, dba Child Health Plan Plus (CHP+) as compared to market penetration for the Colorado Child Health Plan [existing prior to CHP+ and Title XXI]	Data Sources: S-CHIP administrative data comparing enrollment in CHP+ with enrollment in CCHP, as a percentage of the number of uninsured children Methodology: Computation of year-end CHP+ and CCHP enrollment totals divided by number of S-CHIP-eligibles Numerator: (FFY 1998 CCHP, as of 4/1/98, the last date of enrollment) 14,086; (FFY 1999 S-CHIP, or CHP+, as of 9/30/99) 21,289 Denominator: 69,157 (FFY98 & FFY99) Progress Summary: The percentage of uninsured children at or below 185% FPL enrolled in the pre-existing, outpatient-only CCHP program was 20.4% as of April, 1998. The percentage of uninsured children in the same income range enrolled in the S-CHIP program is 30.8%, representing a 51% increase in market penetration.
OBJECTIVES RELATED TO INCREASING MEDICAID ENROLLMENT		
		Data Sources: Methodology: Numerator: Denominator: Progress Summary:

Table 1.3

OBJECTIVES RELATED TO INCREASING ACCESS TO CARE (USUAL SOURCE OF CARE, UNMET NEED)

2. Coordinate and consolidate with other health care programs providing services to children to create a seamless health care delivery system for low-income children 3. Acquire contracts to provide statewide coverage	2a) Enroll 66% of children currently receiving benefits through the outpatient Colorado Child Health Plan into the comprehensive Child Health Plan Plus by July 1, 1998 2b) Enroll 50% of children who previously received services through the Colorado Indigent Care Program into the Child Health Plan Plus by July 1, 1999. 2c) Maintain that 50% of referrals from CHP+ to Medicaid enroll in Medicaid 3a) Secure HMO coverage by one or more HMOs in each of the 63 Colorado counties	Data Sources: Administrative data Methodology: Using the final enrollment total for the outpatient CCHP program, as of the last date of enrollment — 3/15/98 — or 14,086 enrollment as of 4/1/98, 66% of that total was computed (9,297). Then the total July 1, 1999, enrollment in the Title XXI CHP+ program (6,862) was found in administrative monthly enrollment data, using the updated SFY year-end report run 9/13/98. Numerator: 2a) 6,862; 2b) 17,929; 2c) unknown; 3a) 29 Denominator: 2a) 14,086; 2b) unknown; 2c) approx. 550/mo.; 3a) 63 Progress Summary: 2a) By July 1, 1998, 48.7% of the children who were receiving benefits from the outpatient CCHP program, during its final month, had been enrolled into the Title XXI CHP+ program. It is not known how many additional CCHP families chose to enroll their children in CHP+ at a later time, after some lapse in coverage, thus increasing the proportion of CCHP enrollees who chose to enroll in CHP+. 2b) The Colorado Indigent Care Program (CICP), reimbursing partial cost of treating uninsured families under 185% FPL, does not maintain an eligibility system, only a claims payment system. Colorado is working with both CICP and the Colorado Medicaid program to develop a common eligibility system that would allow tracking of enrollees. This, however, is not expected to be fully operational before 2001. 2c) See Section 1.2.1 3a) 46% of Colorado's counties offer HMO coverage by one or more HMOs. Exceptions are rural counties where HMO service delivery is inaccessible. Since these 29 counties include the majority of the metropolitan areas in the state, it can be said that 84% of all CHP+ eligibles live in HMO counties (using the sum of eligibles in all HMO counties). *(Please see Attachment A: Enrollment in Health Maintenance Organizations, and Attachment B: Service Delivery Table.)* CHP+ is currently reviewing options for providing coverage in rural areas where the remaining 16% of Colorado's eligibles reside.

Table 1.3		
		The authorizing legislation for the CHP+ program requires that health care services be delivered to CHP+ enrollees through Medicaid managed care organizations wherever possible. At the time of the submission of the Colorado Title XXI State Plan, two Medicaid HMOs in the State of Colorado had statewide service area licenses. The CHP+ program hoped to have statewide HMO service delivery for its enrollees within the first year of the program through these two plans. Since then, one HMO terminated its contracts with both the Colorado Medicaid program and CHP+, and the other has committed to serving three counties in the rural West Slope region of the state. In those areas where HMO services are not available, CHP+ provides comprehensive benefits to enrollees through the provider network developed by the predecessor CCHP program. This network was developed by the University of Colorado Health Sciences Center, and the State has been able to contract with the providers in this network. An RFP is currently under development to procure the services of a Network Administrator who will provide a wide range of administrative tasks for the network, including network provider recruitment, contracting, and credentialing; quality improvement and utilization management activities; claims administration; and information systems reporting.

Table 1.3

OBJECTIVES RELATED TO USE OF PREVENTIVE CARE (IMMUNIZATIONS, WELL-CHILD CARE)

4. Improve health status of children in Colorado with a focus on preventive and early primary treatment	4a. Ninety percent (90%) of S-CHIP enrolled children under two years old receive basic immunization series 4b. Ninety percent (90%) of 13-year-olds receive required immunizations 4c. Seventy-five percent (75%) of children under 15 months receive recommended number of well-child visits 4d. Seventy-five percent (75%) of three, four, five, and six-year-olds receive at least one well-child visit during the year 4e. Seventy-five percent (75%) of children 12 through 17 receive at least one well-care visit during the year.	Data Sources: Although Colorado does not have the data to report HEDIS measures for its S-CHIP program, two other sources of data are available. First the Colorado Medicaid program requires its contracted plans, which include all but one of the CHP+ plans, to report HEDIS measures on an annual basis. Currently, Colorado Medicaid requires reporting of the five CHP+-identified measures. Secondly, the Colorado Business Group on Health (CBGH), a large employer coalition, annually reports commercial HEDIS measures for plans with which its members have contacts. The CBGH requires reporting of two of the CHP+-identified measures, which CHP+ will use as an indicator. Methodology: n/a Numerator: n/a Denominator: n/a Progress Summary: HMOs that serve the CHP+ population do not have adequate enrollment for FFY 1998 or FFY 1999 to be able to report HEDIS measures on their CHP+ population for those years. After extensive discussions with HMOs, it now appears that HEDIS measures that are specific to CHP+ enrollees will not be reported until the year 2001 for year 2000 plan experience. CHP+ will use baseline ranges from the Colorado Medicaid program and the CBGH to gauge its progress in meeting performance objectives. CHP+ will continue to report Medicaid and commercial measures in its 2000 and 2001 annual reports. The Quality Improvement Working Group of the CBHP Policy Board has made recommendations regarding the development of a Quality Improvement Plan *(See Attachment C: Quality Improvement Goals)*.

Table 1.3		
OTHER OBJECTIVES		
5. Do not "crowd out" employer coverage	5a. Maintain the proportion of children ≤ 185% FPL who are covered under an employer-based plan, taking into account decreases due to increasing health care costs or a downturn in the economy	Data Sources: Administrative data Methodology: The enabling legislation for CHP+ mandated that enrollees in CHP+ cannot have had comprehensive health care coverage for at least three months prior to enrollment in CHP+. It then can be assumed that the total number of enrollees in Colorado's S-CHIP program have not caused "crowd-out" of employer-based coverage. Numerator: n/a Denominator: n/a Progress Summary: n/a

SECTION 2. BACKGROUND

This section is designed to provide background information on CHIP program(s) funded through Title XXI.

2.1 How are Title XXI funds being used in your State?

2.1.1 List all programs in your State that are funded through Title XXI. (Check all that apply.)

___ Providing expanded eligibility under the State's Medicaid plan (Medicaid CHIP expansion)

Name of program: _____

Date enrollment began (i.e., when children first became eligible to receive services): _____

_X_ Obtaining coverage that meets the requirements for a State Child Health Insurance Plan (State-designed CHIP program)

Name of program:

The Children's Basic Health Plan (CBHP) dba Child Health Plan Plus (CHP+)

Date enrollment began (i.e., when children first became eligible to receive services):

4/22/98

___ Other - Family Coverage

Name of program: _____

Date enrollment began (i.e., when children first became eligible to receive services): _____

___ Other - Employer-sponsored Insurance Coverage

Name of program: _____

Date enrollment began (i.e., when children first became eligible to receive services): _____

___ Other - Wraparound Benefit Package

Name of program: _____

Date enrollment began (i.e., when children first became eligible to receive services): _____

___ Other (specify) _____

Name of program: _____

Date enrollment began (i.e., when children first became eligible to receive services): _____

Colorado's Title XXI, initiated by House Bill 97-1304 and implemented by House Bill 98-1325 as the State's S-CHIP, called Child Health Plan Plus (CHP+), began enrolling children on April 22, 1998. CHP+ is a state-designed program, offering comprehensive health insurance to children under age 19 whose income is at or below 185% of the federal poverty level. CHP+ was developed out of the experience and structure of the previous Colorado Child Health Plan (CCHP), which had offered only outpatient services.

The CHP+ program is one of several state efforts to provide coverage to Colorado's uninsured children, with Medicaid being the other major program. When Congress put into legislation the Children's Health Insurance Program for all states, Colorado chose to offer a stand-alone program in an effort to remove the sigma of "public assistance" that often has been associated with Medicaid.

Benefits provided by CHP+ are modeled after the Standard Plan, as defined in Colorado's small group insurance reform law, to comply with the legislative mandate that it be based on a private insurance model. Funding is appropriated by the State's General Assembly yearly, which sets limits on enrollment.

In accordance with the State's mandate for privatization within CHP+, a private organization is contracted to do the marketing and outreach, eligibility and enrollment, premium-collection, and information systems management. Administration, policy-

development, and rule-making responsibilities lie within the Department and the State-appointed Children's Basic Health Plan Policy Board. Privatization is accomplished as well through collaboration with community organizations and private contractors for ongoing program design, outreach, and evaluation.

2.1.2 **If State offers family coverage:** Please provide a brief narrative about requirements for participation in this program and how this program is coordinated with other CHIP programs.

Colorado's S-CHIP does not currently offer family coverage.

2.1.3 **If State has a buy-in program for employer-sponsored insurance:** Please provide a brief narrative about requirements for participation in this program and how this program is coordinated with other CHIP programs.

Colorado is exploring options to provide subsidized coverage to S-CHIP-eligible children through an employer buy-in program *(See Attachment D: "Establishing a Colorado Health Insurance Employer Buy-In for Kids: Issues and Options," by Barbara Yondorf and Sarah Schulte)*. The Program has applied for grant funding to study the feasibility of providing such an option.

2.2 What environmental factors in your State affect your CHIP program? (Section 2108(b)(1)(E))

2.2.1 How did pre-existing programs (including Medicaid) affect the design of your CHIP program(s)?

Prior to its S-CHIP program, Colorado had the usual mix of Medicaid programs operating (including BabyCare/KidsCare and Ribicoff expansions -- all generally at the federal minimum participation levels -- as well as the EPSDT program available to children under age 21). A significant federally-qualified health center (FQHC) and Rural Health Clinic network also operates in the state, including an FQHC- and public/children's hospital-based HMO, making FQHCs the major primary care provider to Medicaid enrollees. Significant Disproportionate Share Hospital (DSH) funds flow primarily to public hospitals.

Two State-only programs also pre-date the S-CHIP/CHP+ program.

- The Colorado Indigent Care Program (CICP) partially reimburses providers -- primarily public hospitals and FQHCs -- for care delivered to uninsured Coloradans.
- The predecessor outpatient Colorado Child Health Plan (CCHP) covered children

up to age 13 for primary care services, mostly in rural areas, through a network of physicians recruited by the University of Colorado Health Sciences Center, the Colorado Chapter of the American Academy of Pediatrics, and other advocates. The CCHP program began enrolling children in 1992, and by 1997 had a little over 14,000 children enrolled. When the Federal Title XXI legislation was signed in 1997, a statewide network to serve these children had been developed and put in place.

Both State-only programs had, and continue to have, a significant effect upon S-CHIP/CHP+. For example:

- Existing staff familiar with the CCHP model and operations, and CCHP enrollees who "rolled over" to CHP+, gave the new program a quick start in Colorado.
- CCHP providers continue as CHP+ Network providers, which is particularly important in the rural areas, where HMOs do not offer coverage to CHP+ enrollees.
- CCHP providers in urban areas provide immediate care to many CHP+ enrollees in the period of time between approval of CHP+ eligibility, and enrollment into the HMO selected to provide ongoing care.
- Because of the continuing availability of CICP, some families decline to enroll in CHP+. These families prefer to access and pay for care on a minimal sliding fee scale, only as their children need it, instead of enroll for long-term health insurance coverage under CHP+, which possibly would require paying a low monthly premium *(See Section 3.3.2 for explanation of who pays premiums and copays).*

Design features of CHP+ that followed the CCHP model include:

- Use of the State-managed network, including administrative components and providers; capitated primary care physician procedures and rates; and FFS reimbursement set at 120% of Colorado Medicaid rates
- Eligibility determination policy and procedures, including an asset test. [*Note: The State has since abolished the asset test, as of December, 1999. The effects of this change will be reported in the FFY 2000 annual report*.]
- Maximum income eligibility set at 185% of FPL

2.2.2 Were any of the pre-existing programs "State-only" and if so what has happened to that program?

___ No pre-existing programs were "State-only"

_X_ One or more pre-existing programs were "State only." Describe current status of program(s): Is it still enrolling children? What is its target group? Was it folded into CHIP?

The CCHP program sunsetted as the S-CHIP/CHP+ program was implemented. State funding was transferred to the CBHP Trust Fund, and matched with federal

Title XXI funds. The CICP program's coverage of children is under review by the CBHP Policy Board, the Department, and by the General Assembly. Integrated eligibility policies may result from this review.

2.2.3 Describe changes and trends in the State since implementation of your Title XXI program that "affect the provision of accessible, affordable, quality health Insurance and healthcare for children." (Section 2108(b)(1)(E))
Examples are listed below. Check all that apply and provide descriptive narrative if applicable. Please indicate source of information (e.g., news account, evaluation study) and, where available, provide quantitative measures about the effects on your CHIP program.

_X_ Changes to the Medicaid program

___ Presumptive eligibility for children
___ Coverage of Supplemental Security Income (SSI) children
___ Provision of continuous coverage (specify number of months ___)
___ Elimination of assets tests
_X_ Elimination of face-to-face eligibility interviews
_X* Easing of documentation requirements

*Minimal verification, always on record, had not been used in Colorado until spring 1999, when training was instituted for DSS eligibility staff for this component in the Medicaid enrollment process.

_X_ Impact of welfare reform on Medicaid enrollment and changes to AFDC/TANF (specify)

An increase in the Medicaid-only population and a decrease in the Medicaid/Financial caseload was observed.

_X_ Changes in the private insurance market that could affect affordability of or accessibility to private health insurance

_X_ Health insurance premium rate increases
___ Legal or regulatory changes related to insurance
___ Changes in insurance carrier participation (e.g., new carriers entering market or existing carriers exiting market)
___ Changes in employee cost-sharing for insurance

___ Availability of subsidies for adult coverage
___ Other (specify) _____

___Changes in the delivery system
___ Changes in extent of managed care penetration (e.g., changes in HMO, IPA, PPO activity)
___ Changes in hospital marketplace (e.g., closure, conversion, merger)
_X_ Other (specify) __**See notes below.**_____

_X_ Development of new health care programs or services for targeted low-income children (specify)

Both Colorado's Medicaid and S-CHIP programs are exploring ways to add/expand dental coverage to their health care benefits packages.

___ Changes in the demographic or socioeconomic context
___ Changes in population characteristics, such as racial/ethnic mix or immigrant status (specify)_____
___ Changes in economic circumstances, such as unemployment rate (specify) _____
___ Other (specify)_____
_X_ Other (specify) _**See notes below.**_____

Notes to 2.2.3. Trends/changes to environment:

The following environmental factors may be affecting CHP+ enrollment, access and costs:

Related to the Delivery System —

- Health care coverage costs are rapidly inflating; in response, the General Assembly has approved a 5% increase for SFY 00-01.
- HMO market volatility and recent financial losses, combined with the small size of the S-CHIP/CHP+ enrollee pool, may reduce the number of HMOs willing to offer CHP+ coverage, and may also limit the networks that participating HMOs will offer to CHP+ enrollees. S-CHIP/CHP+ is proposing innovative risk pooling arrangements, and other initiatives, to respond to these issues.
- Health professional shortages, particularly dentists and rural providers, affect access, benefit designs, and costs.

Related to Demographic or Socioeconomic Context —

- Demographic trends include rapid migration into the state, including a high proportion of

young families. Increases in numbers of uninsured children are likely to result from a higher concentration of low-wage jobs without benefits. Several Colorado counties are among the fastest growing in the US. These effects are difficult to quantify, particularly since the Census base data is now a decade old.

- The State's financing base has been affected by the Colorado Constitutional Amendment limits on taxes and budget growth. Tobacco funds may ease this situation; benefit expansions (e.g., dental), premium structures, enrollment rates and capitation levels may all be affected in future years by funding levels.
- Lack of current and relevant demographic data makes accurate, detailed and timely measurement of market penetration difficult, primarily because the exact number of eligibles is not known, but only estimated.

Related to Other Trend/Changes —

- Federal administrative requirements on the State, coupled with the 10% limitation on FFP for administrative costs, have affected the State's ability to adequately staff the program, to market and grow it, to develop and implement program systems, and to fully respond to all of the Federal and State accountability requirements. This has been especially problematic in the start-up phases of the program.
- Studies on specific related aspects of Colorado's CHIP implementation are available. *(See attachment list in Section 4.6)*.

SECTION 3. PROGRAM DESIGN

This section is designed to provide a description of the elements of your State Plan, including eligibility, benefits, delivery system, cost-sharing, outreach, coordination with other programs, and anti-crowd-out provisions.

3.1 Who is eligible?

3.1.1 Describe the standards used to determine eligibility of targeted low-income children for child health assistance under the plan. For each standard, describe the criteria used to apply the standard. If not applicable, enter "NA."

(See Table 3.1.1)

Table 3.1.1			
	Medicaid CHIP Expansion Program	**State-designed CHIP Program**	**Other CHIP Program**
Geographic area served by the plan (Section 2108(b)(1)(B)(iv))		Statewide	
Age		Less than 19 years old	
Income (define countable income)		Household income at or below 185% FPL*	
Resources (including any standards relating to spend downs and disposition of resources)		Vehicle equity - $4,500 asset Protection** Business equity - $50,000 asset Protection** Family size deduction - $2,500/family member asset protection**	
Residency requirements		Colorado resident (no duration Requirement	
Disability status		NA	
Access to or coverage under other health coverage (Section 2108(b)(1)(B)(I))		Cannot have been covered under employer-based insurance for 3 months prior to application, with the employer contributing at least 50% of the premiums, unless the child lost insurance due to loss of or change in employment	
Other standards (identify and describe)			

Notes to Table 3.11

- **FFY 98 and FFY 99 -- The asset test and other resource requirements have been removed from CHP+ eligibility criteria, and the definition of income has been simplified, as of December 1999. This is expected to have significant impact on enrollment rates for FFY 2000.**
- Income for FFY 98 and FFY 99, specified in the table above, includes:
    - Wages;

- Self-employment income less business deductions;
- Unemployment compensation;
- AND benefits;
- SSI benefits, except for benefits received by minors; retirement and pension benefits, including OAP
- Income from rental property;
- Commissions, bonuses, and tips;
- Stipends;
- College grants and scholarships exceeding the cost of tuition and books;
- Interest earnings and capital gains from savings accounts, stocks, bonds and other similar securities transactions;
- Intangible income, such as room and board

- Disallow all:
  - documented child support payments;
  - medical bills incurred by the family due and payable within 12 months;
  - daycare expenses

**Total resources for the family cannot be less than $0. Any resources above these protections are considered income.

3.1.2 How often is eligibility redetermined?

Table 3.1.2			
Redetermination	Medicaid CHIP Expansion Program	State-designed CHIP Program	Other CHIP Program* _____
Monthly			
Every six months			
Every twelve months		X	
Other (specify)			

3.1.3 Is eligibility guaranteed for a specified period of time regardless of income changes? (Section 2108(b)(1)(B)(v))

_X_ Yes Þ Which program(s)? State-designed S-CHIP program

For how long? 12 months

___ No

3.1.4 Does the CHIP program provide retroactive eligibility?

_X_ Yes Þ Which program(s)? State-designed S-CHIP program

How many months look-back? To the date the application was received, if the child is determined eligible.

___ No

3.1.5 Does the CHIP program have presumptive eligibility?

___ Yes Þ Which program(s)?

Which populations?

Who determines?

_X_ No

3.1.6 Do your Medicaid program and CHIP program have a joint application?

_X_ Yes Þ Is the joint application used to determine eligibility for other State programs? If yes, specify. Medicaid

___ No

3.1.7 Evaluate the strengths and weaknesses of your *eligibility determination* process in increasing creditable health coverage among targeted low-income children

(See Section 5.1.1.)

3.1.8 Evaluate the strengths and weaknesses of your *eligibility redetermination* process in increasing creditable health coverage among targeted low-income children. How does the redetermination process differ from the initial eligibility determination process?

(See Section 5.1.1.)

3.2 What benefits do children receive and how is the delivery system structured? (Section 2108(b)(1)(B)(vi))

3.2.1 Benefits

Please complete Table 3.2.1 for each of your CHIP programs, showing which benefits are covered, the extent of cost sharing (if any), and benefit limits (if any).

Table 3.2.1 CHIP Program Type S-CHIP			
Benefit	Is Service Covered? (✓ = yes)	Cost-Sharing (Specify)	Benefit Limits (Specify)
Inpatient hospital services	✓	$0	
Emergency hospital services	✓	$5 copay for up to 150% FPL $15 copay for 151% - 185% FPL	
Outpatient hospital services	✓	$0	
Physician services	✓	$0 copay for under 101%FPL $2 copay for 101% - 150% FPL $5 copay for 151% - 185% FPL	
Clinic services	✓	Primary care $0 copay for all income groups Other care: $0 copay for under 101%FPL $2 copay for 101% - 150% FPL $5 copay for 151% - 185% FPL	
Prescription drugs	✓	$0 copay for under 101%FPL $1 copay for 101% - 150% FPL $3 copay for generic for 151% - 185% FPL $5 copay for brand name for 151% - 185% FPL	
Over-the-counter medications			
Outpatient laboratory and radiology services	✓	$0	

Table 3.2.1 CHIP Program Type S-CHIP			
Benefit	Is Service Covered? (✓ = yes)	Cost-Sharing (Specify)	Benefit Limits (Specify)
Prenatal care	✓	$0	
Family planning services	✓	$0	
Inpatient mental health services	✓	$0	45 days of inpatient mental health services are covered.
Outpatient mental health services	✓	$0 copay for under 101%FPL $2 copay for 101% - 150% FPL $5 copay for 151% - 185% FPL	Outpatient mental health services are covered up to a 20-visit limit. Treatment for neurobiologically based mental illnesses are treated as any other illness and not subject to this limit.
Inpatient substance abuse treatment services	✓	$0	Limited to treatment for medical detoxification only.
Residential substance abuse treatment services			
Outpatient substance abuse treatment services	✓	$0 copay for under 101%FPL $2 copay for 101% - 150% FPL $5 copay for 151% - 185% FPL	Outpatient substance abuse treatment covered up to a maximum of 20 visits.
Durable medical equipment	✓	$0	$2,000 maximum per year.
Disposable medical supplies			
Preventive dental services			
Restorative dental services			

Table 3.2.1 CHIP Program Type S-CHIP			
Benefit	Is Service Covered? (✓ = yes)	Cost-Sharing (Specify)	Benefit Limits (Specify)
Hearing screening	✓	$0 copay for under 101%FPL $2 copay for 101% - 150% FPL $5 copay for 151% - 185% FPL	
Hearing aids	✓	$0	Hearing aides are covered for congenital and traumatic injury with a maximum payment of $800 paid by the plan per year.
Vision screening	✓		
Corrective lenses (including eyeglasses)	✓		$50 credit towards the purchase of corrective lenses per benefit period.
Developmental assessment	✓	$0 copay for under 101%FPL $2 copay for 101% - 150% FPL $5 copay for 151% - 185% FPL	
Immunizations	✓	$0	
Well-baby visits	✓	$0	
Well-child visits	✓	$0	
Physical therapy	✓	$0 copay for under 101%FPL $2 copay for 101% - 150% FPL $5 copay for 151% - 185% FPL	30 visits limit of any combination of all therapy services (physical, speech and occupational) per diagnosis per benefit period.

Table 3.2.1 CHIP Program Type S-CHIP			
Benefit	Is Service Covered? (✓ = yes)	Cost-Sharing (Specify)	Benefit Limits (Specify)
Speech therapy	✓	$0 copay for under 101%FPL $2 copay for 101% - 150% FPL $5 copay for 151% - 185% FPL	30 visits limit of any combination of all therapy services (physical, speech and occupational) per diagnosis per benefit period.
Occupational therapy	✓	$0 copay for under 101%FPL $2 copay for 101% - 150% FPL $5 copay for 151% - 185% FPL	30 visits limit of any combination of all therapy services (physical, speech and occupational) per diagnosis per benefit period.
Physical rehabilitation services			
Podiatric services	✓	$0 copay for under 101%FPL $2 copay for 101% - 150% FPL $5 copay for 151% - 185% FPL	
Chiropractic services			
Medical transportation	✓	$0	
Home health services	✓	$0 copay for under 101%FPL $2 copay for 101% - 150% FPL $5 copay for 151% - 185% FPL	
Nursing facility	✓	$0	Care must follow a hospital confinement and the skilled nursing facility confinement must be the result of an injury or sickness that was the cause of the hospital confinement. Benefits will not be paid for custodial care or maintenance care or when maximum medical improvement is achieved and no further significant measurable improvement can be anticipated.

Table 3.2.1 CHIP Program Type S-CHIP			
Benefit	Is Service Covered? (✓ = yes)	Cost-Sharing (Specify)	Benefit Limits (Specify)
ICF/MR			
Hospice care	✓	$0	
Private duty nursing			
Personal care services			
Habilitative services			
Case management/Care coordination	✓	$0	Covered when medically necessary.
Non-emergency transportation			
Interpreter services			
Other (Specify)			
Other (Specify)			
Other (Specify)			

3.2.2 Scope and Range of Health Benefits (Section 2108(b)(1)(B)(ii))

Please comment on the scope and range of health coverage provided, including the types of benefits provided and cost-sharing requirements. Please highlight the level of preventive services offered and services available to children with special health care needs. Also, describe any enabling services offered to CHIP enrollees. (Enabling services include non-emergency transportation, interpretation, individual needs assessment, home visits, community outreach, translation of written materials, and other services designed to facilitate access to care.)

Title XXI allowed states some flexibility to choose the scope of health insurance coverage offered under CHIP programs. Colorado chose to offer S-CHIP health benefits coverage with an aggregate actuarial value which is actuarially equivalent to the benefits in at least one of the benchmark benefit packages. Colorado's benefit package exceeds the actuarial value of Federal Employee Health Benefit Plan (FEHBP) coverage -- coverage that is generally offered to Colorado State employees, and offered under the largest insurer in Colorado.

Colorado based its S-CHIP benefit package on the Colorado Standard and Basic Health Benefit Plans, which are regulated by the Colorado Division of Insurance and are required for use in Colorado's small employer market. The actuarial value of these plans surpassed the value of the benchmark plans and met state statutory requirements to provide a commercial-like plan to S-CHIP enrollees. The Standard and Basic Health Benefit Plans are the benefit packages that an employee would be most likely to receive when working for a small employer. These plans are updated annually through a committee process in order to stay current with market trends.

Colorado expanded on the Standard and Basic Health Benefits Plans by making additional services available to S-CHIP enrollees. These added benefits include hearing aids, a higher maximum amount for durable medical equipment, outpatient substance abuse treatment, vision care, lower co-payments, and no deductibles.

Colorado's S-CHIP is working with the Title V, Maternal Child Health (MCH), Health Care Program for Children with Special Needs (HCP) to identify children enrolled in S-CHIP who may be eligible for the wrap-around services provider under HCP. There is a checklist on the application that includes questions to identify a child with special needs. If the applicant identifies that a child may have special needs, a copy of the application is forwarded to the HCP program. HCP coordinators then contact the family to screen for special needs and enroll the child in HCP, if necessary. Colorado has also applied for grant funding to expand its Medicaid Safety Net Project to S-CHIP. If funded, this project would support the development of ongoing systems to identify special needs children and provide assistance to S-CHIP HMOs to ensure that the children receive

needed services.

3.2.3 Delivery System

Identify in Table 3.2.3 the methods of delivery of the child health assistance using Title XXI funds to targeted low-income children. Check all that apply.

Table 3.2.3			
Type of delivery system	Medicaid CHIP Expansion Program	State-designed CHIP Program	Other CHIP Program* _____
A. Comprehensive risk managed care organizations (MCOs)			
Statewide?	___ Yes ___ No	___ Yes _X_ No	___ Yes ___ No
Mandatory enrollment?	___ Yes ___ No	_X_ Yes, if available ___ No	___ Yes ___ No
Number of MCOs		6	
B. Primary care case management (PCCM) program			
C. Non-comprehensive risk contractors for selected services such as mental health, dental, or vision (specify services that are carved out to managed care, if applicable)			
D. Indemnity/Departmental-operated managed care system (specify services that are carved out to FFS, if applicable)		A state-contracted managed-care-like network is utilized in 34 Colorado counties	
E. Other (specify)			

3.3 How much does CHIP cost families?

3.3.1 Is cost sharing imposed on any of the families covered under the plan? (Cost sharing includes premiums, enrollment fees, deductibles, coinsurance/

copayments, or other out-of-pocket expenses paid by the family.)
___ No, skip to section 3.4
_X_ Yes, check all that apply in Table 3.3.1

Table 3.3.1			
Type of cost-sharing	Medicaid CHIP Expansion Program	State-designed CHIP Program	Other CHIP Program_____ _____
Premiums		X	
Enrollment fee			
Deductibles			
Coinsurance/copayments*		X	
Other (specify) _____			

* See Table 3.2.1 for detailed information.

3.3.2 **If premiums are charged:** What is the level of premiums and how do they vary by program, income, family size, or other criteria? (Describe criteria and attach schedule.) How often are premiums collected? What do you do if families fail to pay the premium? Is there a waiting period (lockout) before a family can re-enroll? Do you have any innovative approaches to premium collection?

Families are required to pay a monthly premium that is based on the following sliding fee scale:

1. For families with incomes less than 101% of the federal poverty level, the monthly premium is waived, except for copays for emergency room services ($5).
2. For families with incomes from 101% to 150% FPL, the premium is:
   a) $9 per month for a single-enrolled child;
   b) $15 per month for two or more children.
3. For families with incomes from 151% to 170% FPL, the premium is:
   a) $15 per month for a single enrolled child;
   b) $25 per month for two or more enrolled children.
4. For families with incomes from 171% to 185% FPL, the premium is:
   a) $20 per month per single enrolled child;
   b) $30 per month for two or more enrolled children.

(See table in Section3.3.6, and 3.6.1 under Benefit Package Design.)

3.3.3 **If premiums are charged:** Who may pay for the premium? Check all that apply. (Section 2108(b)(1)(B)(iii))

_X_ Employer
_X_ Family
_X_ Absent parent
_X_ Private donations/sponsorship
___ Other (specify) _____

3.3.4 **If enrollment fee is charged:** What is the amount of the enrollment fee and how does it vary by program, income, family size, or other criteria?

Not applicable.

3.3.5 **If deductibles are charged:** What is the amount of deductibles (specify, including variations by program, health plan, type of service, and other criteria)?

Not applicable.

3.3.6 How are families notified of their cost-sharing requirements under CHIP, including the 5 percent cap?

Families are notified through several mechanisms:

- Informational brochures that are provided with the application have cost-sharing requirements described.
- Enrollees are provided information about cost-sharing requirements within the letter of notification of enrollment.
- Payment coupons are provided with the enrollment packet.
- If clients are delinquent, letters are provided reminding them of their cost-sharing requirements and delinquent amount.
- Families are notified about the cost-sharing cap in the notification of enrollment and the enrollment packet.

3.3.7 How is your CHIP program monitoring that annual aggregate cost sharing does not exceed 5 percent of family income? Check all that apply below and include a narrative providing further details on the approach.

_X__ Shoebox method (families save records documenting cumulative level of cost

sharing)

___ Health plan administration (health plans track cumulative level of cost sharing)

___ Audit and reconciliation (State performs audit of utilization and cost sharing)

___ Other (specify)_____

Families are notified by letter of their enrollment into the program, their cost-sharing requirements, and the calculated five- percent cap rate. Families are responsible for saving records documenting paid co-payments and premium payments toward that cap rate. Once a family reaches the five percent cap, families call the program office and stickers are sent to the family to place on their enrollment cards that tell providers that there are no co-pay requirements.

3.3.8 What percent of families hit the 5 percent cap since your CHIP program was implemented? (If more than one CHIP program with cost sharing, specify for each program.)

No families have reported that they have reached the five- percent cap. It may be some families *have* reached the limit, but have either not kept accurate records or have chosen not to report it.

3.3.9 Has your State undertaken any assessment of the effects of premiums on participation or the effects of cost sharing on utilization, and if so, what have you found?

Several studies have been conducted in Colorado that have attempted to determine if the premium requirement has an effect on enrollment in S-CHIP. With the assistance of community organizations, including the Colorado Community Health Network (CCHN), Colorado's Children's Basic Health Plan Policy Board has reviewed available data. This resulted in recommendations to the Colorado General Assembly's Joint Budget Committee for review, with the potential for adjustments to the premium structure. The Policy Board's recommendations include revisions to the current premium structure, possibly including a low, annual premium, rather than monthly premiums. Currently, there are no changes to the premium structure anticipated.

CCHN conducts an ongoing survey of children who come through this agency, who would appear to be CHIP-eligible, but who choose not to enroll in Colorado's S-CHIP program. Reasons for this decision are explored in a brief survey. As of July 1999, data showed that the "most common reason for not enrolling children in CHP+" was families' perception that the premium they would have to pay is "too high." This appeared to be the prevailing view of families with incomes from 101% to 150% of poverty. Approximately 63% of the families in this income range said premiums were a

barrier to enrollment. *(See Attachment E: Colorado Community Health Network: Outreach Project, CHP+ Survey.)*

Another study, by Dr. Allison Kempe of The Children's Hospital in Denver, examined reasons that Hispanic and non-Hispanic families gave for choosing not to submit an application, after requesting one. In the non-Hispanic sample (n=276), 14.8% reported "none" when asked how much they could afford to pay. When asked if there *should* be a monthly premium and copays, 16.1% of non-Hispanics said "no." The most common reasons among non-Hispanics for not submitting an application were: got other health insurance (21.9%), had problems getting the paperwork (13.9%), and thought income was too high (10.4%).

Similarly, among the Hispanic sample (n=156), 19.3% answered "none" to how much premium they could afford to pay, and 15.1% said a monthly premium should not be required. The most common reasons among Hispanics were: thought income was too high (17.6%), got other insurance (15.3%), and had problems getting the paperwork (14.4%).

These reasons would seem to indicate that, on the issue of difficulty in paying premiums, there were no real differences between Hispanics and non-Hispanics, and premiums were not expressed as a major problem. No significance tests or analyses of results by income were conducted, however, to explore where the differences might be significant. Small and unequal sample sizes make comparisons somewhat problematic without further testing.

Two other studies, by Sundel Research, Inc., of Colorado, examined reasons for failing to maintain continuous coverage (re-enrollees; n=100), and for disenrollment (disenrollees; n=257) from Colorado's S-CHIP program *(See Attachments F and G: Sundel Research, Inc.," Colorado Child Health Plan Plus Dis-Enrollee Study" and "Colorado Child Health Plan Plus Re-Enrollee Study").* Only significant (sig.≤.05) results were reported in the Sundel studies.

In open-ended questions, premiums were not reported as a significant deterrent to program enrollment, based on direct questions about them. Only 4% of the disenrollees in the study indicated premiums as the main reason for not renewing their enrollment. However, 21% of those who said they had to pay premiums also reported it was somewhat difficult or very difficult to pay them (16% of total disenrollees). Interestingly, an analysis of ethnic groups indicated Hispanic disenrollees' families (approx. one-third), more often than non-Hispanic families (approx. two-thirds), reported it was easy or very easy to pay premiums and copays. These

differences, though significant, were not systematic, and unequal sample sizes could make this a questionable finding. *The most common reason for disenrollment* was getting other health insurance (79% of disenrollees responding to the survey), a reflection of a rising economy.

Similar results were found among families who had a lapse in coverage (re-enrollees). The most common reason for allowing coverage to lapse was

"forgot/procrastinated/misplaced the application" (41% of respondents).
Only 4% indicated premiums as a reason for not renewing coverage on time, but 23% of re-enrollees that said they have to pay premiums said that paying premiums was somewhat or very difficult (15% of total re-enrollees)

Further analyses by the Department of the premium questions by income group indicated no significant differences among income groups on reported ability to pay premiums and copays. However, 22 (37.9%) of the disenrollees' families under 101% of the federal poverty level reported having to pay premiums and copays, when in fact, this income level group does not pay premiums and copays in Colorado. Only three of the 22 reported this was difficult, however.

The above studies are limited by small sample size, and by willing respondents who naturally tend to be more positive toward the program. This is common in a telephone survey. They are valuable, however, in that they suggest a need for further evaluation that would more specifically target the issues that emerged. Some of the issues were: 1) why some families feel their income is too high to be in the S-CHIP program; 2) which income groups are more likely to have difficulty with required premium levels; and 3) whether paying a premium has merit for a population such as that targeted by the S-CHIP program. Tracking of disenrollees is difficult, due to mobility of families. New strategies for accomplishing this can be sought.

In contrast to the above Sundel and Kempe studies, a number of national reports have become available which suggest premiums *can* be a barrier to enrollment. The state is investigating funding and negotiations are underway to examine these effects more closely, as they relate to Colorado's CHP+ program. Important groundwork is being established with an as-yet-to-be-completed study by Judy Glazner (*See Attachment H: "Prices and Affordability of Health Insurance for Colorado's Uninsured Population -- Draft")* on the amount of premiums families can afford at various income levels. This study (n=22,000 households) suggests that for S-CHIP-eligibles under 200% of the federal poverty level, there are no funds available for health care costs, after essential expenses (food, housing, clothing, etc.) are paid. The challenge is to get

families who are not used to paying monthly premiums to understand that paying for something on a monthly basis that they may not need, and paying for it ahead of time, is a valuable investment in their family's well-being.

Another study, led by Sheri Eisert and conducted by Denver Health and Hospitals and the Community Voices organization, focuses on the effects of premiums on enrollment in the CHP+ program and the effects on utilization of having insurance. It is anticipated that results will be made available by early summer

2000, and again by the end of the calendar year, and could be reported in the FFY 2000 annual report.

3.4 How do you reach and inform potential enrollees?

3.4.1 What client education and outreach approaches does your CHIP program use?

Please complete Table 3.4.1. Identify all of the client education and outreach approaches used by your CHIP program(s). Specify which approaches are used (✳=yes) and then rate the effectiveness of each approach on a scale of 1 to 5, here 1=least effective and 5=most effective.

Table 3.4.1						
Approach	Medicaid CHIP Expansion		State-Designed CHIP Program		Other CHIP Program* _____	
	✳ = Yes	Rating (1-5)	✳ = Yes	Rating (1-5)	✳ = Yes	Rating (1-5)
Billboards/Bus Banners			✳	1		
Brochures/flyers			✳	3		
Direct mail by State/enrollment broker/administrative contractor						
Education sessions						
Home visits by State/enrollment broker/administrative contractor			✳	4		
Hotline			✳	4		
Incentives for education/outreach staff						
Incentives for enrollees						
Incentives for insurance agents						
Non-traditional hours for application intake			✳	3		
Prime-time TV advertisements			✳	2		
Public access cable TV						
Public transportation ads			✳	1		
Radio/newspaper/TV advertisement and PSAs			✳	2		
Signs/posters			✳	1		

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Table 3.4.1						
Approach	Medicaid CHIP Expansion		State-Designed CHIP Program		Other CHIP Program* _____	
	✳ = Yes	Rating (1-5)	✳ = Yes	Rating (1-5)	✳ = Yes	Rating (1-5)
State/broker initiated phone calls						
Press coverage			✳	3		
Non-prime time television advertising			✳	3		
Community challenge grants			✳	2		

Colorado's S-CHIP, as a new program, is faced with the combined challenge of: 1) increasing awareness of the program among potential recipients, the "helping hands," and the general community; and 2) generating applications/enrollment. Although an attempt is made to rate each strategy, Colorado postulates that it is *too soon* to evaluate the specific impact of each outreach effort. Over time, it may be more important to educate teachers, coaches, and pastors on the goals of the program to assure ongoing awareness and membership. With limited marketing dollars, Colorado is attempting to impact both important marketing areas.

Additional Notes to Table 3.4.1:

- For tracking purposes, there is a question on the application asking where the applicant heard about CHP+.
- Community Challenge Grants, funded by the Rose Community Foundation, have not been as effective as hoped in generating applications, but have had the *positive* effect of raising visibility of the S-CHIP program in the areas affected. It is expected this could have significant impact for S-CHIP in the future.
- March of Dimes/K-Mart bags for KIDS NOW generated a significant number of inquiries to the Family Health Line.

3.4.2 Where does your CHIP program conduct client education and outreach?

Please complete Table 3.4.2. Identify all the settings used by your CHIP program(s) for client education and outreach. Specify

which settings are used (✳=yes) and then rate the effectiveness of each setting on a scale of 1 to 5, where 1=least effective and 5=most effective.

Table 3.4.2

Setting	Medicaid CHIP Expansion		State-Designed CHIP Program		Other CHIP Program _____	
	✳= Yes	Rating (1-5)	✳ = Yes	Rating (1-5)	✳ = Yes	Rating (1-5)
Battered women shelters						
Community sponsored events			✳	1		
Beneficiary's home			✳	4		
Day care centers			✳	1		
Faith communities			✳[1]			
Fast food restaurants			✳[1]			
Grocery stores			✳[1]			
Homeless shelters - "Urban Peak"			✳			
Job training centers						
Laundromats			✳[1]			
Libraries						
Local/community health centers			✳	5		
Point of service/provider locations			✳	5		

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Table 3.4.2						
Setting	Medicaid CHIP Expansion		State-Designed CHIP Program		Other CHIP Program _____	
	✳= Yes	Rating (1-5)	✳ = Yes	Rating (1-5)	✳ = Yes	Rating (1-5)
Public meetings/health fairs			✳	3		
Public housing						
Refugee resettlement programs						
Schools/adult education sites			✳	3		
Senior centers						
Social service agency			✳	5		
Workplace			✳[1]			
Other (specify)						
Other (specify)						

[1] FFY 2000 activity

Notes to Table 3.4.2:

- The School Free and Reduced Price Lunch (FRM) program has involved intensive effort, with benefits still being realized.
- Brochure distributions through the schools have demonstrated high effectiveness in generating visibility for the program; they are consistently among the *five most frequently mentioned* sites where applicants have heard about the program.
- Satellite Eligibility Determination sites (SEDs) have been very effective in insuring completion of applications for applicants who are aware of these sites.

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- Families in the income groups served by S-CHIP are often highly mobile. In Commerce City, a northern suburb of Denver, some of the schools report 50% of the kids move out every year. This makes steady CHP+ enrollment growth difficult to maintain.

3.4.3 Describe methods and indicators used to assess outreach effectiveness, such as the Number of children enrolled relative to the particular target population. Please be as specific and detailed as possible. Attach reports or other documentation where available.

- *Phone Bank Query*. Every person calling the Program's toll-free number and requesting an application is asked to indicate where they heard about the program; a monthly report tracks all referral sources. (See following Table 1, "Number of Calls Received by Source of Referral.")
- *Application Form Query*. The application form has a voluntary section for applicants to mark where they heard about the program. Because of limited space on the form, however, this mechanism tracks fewer categories than does the phone bank. (See following Table 2, "Number of Applications Received by Source of Referral.")
- *Application Form Numbering*. As of late Fall 1999, every application is being printed with a unique identifier, which helps the State identify the source of the application (DSS, SED site, school, etc.). As applications are sent out – either in bulk to satellite eligibility determination sites and other partner organizations, or individually to families – the application identifiers are entered into a computer system. As applications are returned, the identifiers are compared with those entered into the system to monitor the return rate for the various outside partners.
- *Expanded Database Tracking*. Beginning February 2000, a new integrated database began combining all this information into one consolidated record for each individual, allowing CHP+ to track not only how many applications have been requested as a result of each outreach strategy, but also how many of those applications resulted in enrollments.
- *Enrollments at SED Sites*. CHP+ has 65 satellite eligibility determination (SED) sites statewide, mostly at community health centers and clinics. Every month, CHP+ tracks the number of applications and enrollments generated by those sites, and the accuracy of the applications. Accuracy is defined as the completion of all required elements on the application and inclusion of all required documentation. (See following Table 3, "SED Sites – Applications Received and Accuracy by Site," and subsequent Tables 4 and 5, "CHP+ SED Performance.)
- *Programmatic Outreach*. CHP+ monitors the effectiveness of discrete outreach programs (e.g., school lunch program outreach, community challenge grants) by tracking the number of applications sent out through each program, the number returned and the number of resulting enrollees.

Table 1
Number of Calls Received by Source of Referral (Colorado)
December 1–31, 1999

Where did you hear about the Child Health Plan Ad?	Count	%
Friend/ Relative	141	15.82%
School	67	7.51%
Social Services/ Medicaid	101	11.33%
TV	66	7.40%
Newspaper	54	6.06%
Doctors' Office	58	6.50%
Health Department/ HCP	46	5.16%
Hospital	27	3.03%
Brochure	56	6.28%
Radio-Advertisement	16	1.79%
Work	20	2.24%
Bus/ Poster	10	1.12%
WIC	13	1.45%
Internet	5	0.56%
Church	1	0.11%
Renewal Applications	136	15.26%
Other	74	8.30%
Total	**891**	**100.00%**

Table 2
Number of Applications Received by Source of Referral (Colorado)
December 1-31, 1999

Where did you see or hear about CHP+ and/or Medicaid	Count	%
School	494	22.21%
Social Services	370	16.63%
Doctor's Office	324	14.56%
Friend/ Relative	281	12.63%
Health Department	192	8.63%
Community Health Centers	126	5.66%
Brochure	113	5.08%
TV	128	5.75%
WIC	107	4.81%
Newspaper	25	1.12%
Radio	28	1.25%
Poster	36	1.61%
Total	**2,224**	**100.00%**

Table 3
SED Sites – Applications Received and Accuracy by Site (Colorado)
December 1999

AGENCY	Apps Rec'd	Correct Apps	Accuracy Rate
Tri-County Health Dept.	11	5	45%
Commerce City SD #14	0	0	0%
Westminster School District #50	2	2	100%
Clinica Campesina	18	5	28%
Alamosa Co. Nursing Service	5	3	60%
Sheridan School District	3	2	67%
Cherry Creek SD #5	1	1	100%
People's Clinic	7	4	57%
Chaffee County Nursing Service	2	2	100%
The Children's Hospital	39	16	41%
Denver Health Medical Center	168	125	74%
High Street Primary Care Center	3	2	67%
Inner City Health Center	1	1	100%
LARASA	6	4	67%
Community Health Centers, Inc.	5	3	60%
Upper Arkansas Council of Gov.	0	0	0%
Fremont County Head Start	0	0	0%
Fremont County Nursing Serv.	2	2	100%
Fremont County Family Center	0	0	0%
St. Thomas More Hospital	0	0	0%
Jefferson Cnty. Dept. of Public Health & Environment	6	2	33%
Kit Carson Health Department	13	11	85%
Southern Ute Health Center	0	0	0%
San Juan Health Department	7	5	71%
Larimer Poudre Valley Hospital	0	0	0%
Children's Clinic	25	25	100%
Poudre School District	2	1	50%
Hilltop Resource Center	80	67	84%
Northwest Colorado VNA	4	3	75%
Ute Mountain Ute Health Center	0	0	0%
Montezuma Co. Nursing Service	5	3	60%
West End Family Link Center	0	0	0%
Otero County Health Dept.	14	13	93%
High Plains Comm. Health Center	4	2	50%
Prowers Co. Nursing Service	6	6	100%
Pueblo School-based Wellness Ctrs.	0	0	0%
Pueblo Comm. Health Ctrs., Inc.	26	20	77%
Rio Grande County Public Health	8	6	75%
Teller Co. Public Health & Environment	0	0	0%
Monfort Children's Clinic	3	3	100%
Salud Family Health Center	3	2	67%
Sunrise Community Health Center	6	4	67%
Weld County Health Department	1	0	0%
*DSS	567	N/a	N/a

Table 4
CHP+ Satellite Eligibility Determination (SED) Performance Trends (Colorado)
Applications Received by Site
December 1999

AGENCY	July '99	Aug. '99	Sept. '99	Oct. '99	Nov '99	Dec. '99	**Total**
Tri-County Health Dept.	7	16	15	18	25	11	**133**
Commerce City SD #14	5	4	7	7	4	0	**51**
Westminster School District #50	1	3	2	2	4	2	**28**
Clinica Campesina	12	23	18	17	10	18	**214**
Alamosa Co. Nursing Service	3	6	6	1	1	5	**28**
Sheridan School Dist.	2	2	3	3	3	3	**41**
Cherry Creek SD #5	0	0	0	0	2	1	**3**
People's Clinic	3	0	7	15	3	7	**82**
Chaffee County Nursing Service	3	5	2	2	4	2	**36**
The Children's Hospital	72	37	61	50	56	39	**358**
Denver Health & Hospital	77	123	166	150	58	168	**1133**
High Street Primary Care Center	8	0	0	22	3	3	**53**
Inner City Health Center	0	0	0	0	1	1	**2**
LARASA	7	11	9	9	4	6	**79**
Community Health Centers, Inc.	7	11	14	11	2	5	**80**
Upper Arkansas Council of Gov.	8	0	0	0	0	0	**8**
Fremont County Head Start	0	0	0	0	0	0	**0**
Fremont County Nursing Serv.	0	4	5	5	3	2	**35**
Fremont County Family Center	0	0	3	0	0	0	**3**
St. Thomas More Hospital	3	0	0	0	0	0	**5**
Jefferson County Dept. of Health & Environment	0	0	0	8	3	6	**17**
Kit Carson Health Department	n/a	n/a	6	14	0	13	**33**
Southern Ute Health Center	0	0	0	0	0	0	**0**
San Juan Health Department	6	4	6	10	13	7	**85**
Larimer Poudre Valley Hospital	0	0	0	0	0	0	**0**
Children's Clinic	15	27	29	21	21	25	**239**
Poudre School District	0	1	2	3	5	2	**19**
Hilltop Resource Center	77	61	60	67	89	80	**746**
Northwest Colorado VNA	2	8	4	5	23	4	**69**
Ute Mountain Ute Health Center	0	0	0	0	0	0	**0**
Montezuma Co. Nursing Service	5	7	6	9	7	5	**62**
West End Family Link Center	1	1	2	4	0	0	**11**
Otero County Health Department	18	14	9	3	22	14	**124**
High Plains Comm. Health Center	16	9	9	6	2	4	**75**
Prowers Co. Nursing Service	3	3	7	4	2	6	**37**
Pueblo School-based Wellness Ctrs.	0	0	0	0	0	0	**0**
Pueblo Comm. Health Ctrs., Inc.	12	29	32	16	34	26	**182**
Rio Grande County Public Health	2	1	12	10	1	8	**47**
Teller Co. Public Health & Environment	0	0	0	1	1	0	**11**
Monfort Children's Clinic	3	0	2	3	3	3	**45**
Salud Family Health Center	7	3	1	7	11	3	**65**
Sunrise Community Health Center	7	3	4	7	6	6	**62**
Weld County Health Department	1	1	3	1	2	1	**22**
Total	**393**	**417**	**512**	**511**	**428**	**486**	**4323**
* DSS	435	377	465	547	440	567	**4543**

n/a ~ They were not an SED site at that time.

Table 5
CHP+ Satellite Eligibility Determination (SED) Performance (Colorado)
As of December 31, 1999

County	# of Eligible Children by County*	# of Children Enrolled by County	# of Children Enrolled by SED Sites by County	% of Eligible Children Enrolled by SED Site	% of County's Enrolled Children Enrolled by SED Sites
Adams	5,990	2,311	713	12%	31%
Alamosa	394	200	59	15%	30%
Arapahoe	6,540	1437	316	5%	22%
Archuleta	198	117	52	26%	44%
Bent	86	37	2	2%	5%
Boulder	3,982	685	245	6%	36%
Chaffee	253	175	63	25%	36%
Cheyenne	33	38	8	24%	21%
Conejos	260	272	16	6%	6%
Costilla	121	88	8	7%	9%
Crowley	76	77	77	101%	100%
Delta	589	317	30	6%	9%
Denver	9,854	3,519	1,960	20%	56%
Dolores	51	19	1	2%	5%
Douglas	2,135	142	18	1%	13%
El Paso	9,162	1,513	142	2%	9%
Elbert	340	51	6	2%	12%
Fremont	663	417	86	13%	21%
Garfield	781	283	25	3%	9%
Huerfano	158	78	1	1%	1%
Jefferson	7,031	1,535	137	2%	9%
Kit Carson	115	74	18	16%	24%
Kiowa	19	19	17	89%	89%
La Plata	774	366	103	13%	28%
Las Animas	475	291	6	1%	2%
Larimer	3,567	1,386	541	15%	39%
Lincoln	65	76	2	3%	3%
Logan	300	168	1	<1%	1%
Mesa	2,212	1,883	1,522	69%	81%
Mineral	18	20	5	28%	25%
Moffat	296	124	74	25%	60%
Montezuma	604	359	98	16%	27%
Montrose	802	436	25	3%	6%
Morgan	505	235	5	1%	2%
Otero	401	221	201	50%	91%
Park	262	61	6	2%	10%
Pitkin	201	21	2	1%	10%
Prowers	273	297	236	86%	79%
Pueblo	2,764	535	238	9%	44%
Rio Blanco	145	43	1	1%	2%

Rio Grande	376	147	74	20%	50%
Routt	284	82	17	6%	21%
San Juan	26	13	2	8%	15%
Saguache	252	90	1	<1%	1%
Teller	420	94	19	5%	20%
Weld	3,093	1,197	274	9%	23%
Total	**66,946***	**21,549**	**7,453**		

* In addition, the following counties total 2,211 additional eligibles, but are serviced by SED sites in neighboring counties: Baca, Clear Creek, Custer, Eagle, Gilpin, Grand, Gunnison, Hinsdale, Jackson, Lake, Ouray, Phillips, San Miguel, Sedgwick, Summit, Washington, and Yuma. These additional eligibles bring the total number of eligibles to 69,157.

3.4.4 What communication approaches are being used to reach families of varying ethnic backgrounds?

- *Spanish-language advertising on local Spanish-language television station*. This has generated approximately 30-40% of the CHP+ applications, consistent with an eligible population made up of 30-40% Hispanic persons.
- *LARASA enrollment project.* CHP+ has partnered with Mile High United Way to develop and fund a comprehensive outreach program with the metropolitan Denver chapter of the Latin American Research and Service Agency (LA RASA). Elements of the program include:
  - LA RASA offices serve as satellite eligibility determination (SED) sites for CHP+.
  - A full-time CHP+ outreach worker is funded at LA RASA.
  - A teen outreach program is funded at two local high schools that have predominately Hispanic student bodies.
- *Hispanic service project soccer tournament.* As part of CHP+'s statewide Community Challenge in summer 1999, The Circle of Life, an Hispanic service organization, organized a soccer tournament. Participating teams were asked to submit 20 completed CHP+ applications in lieu of a registration fee. CHP+ received only three completed applications through this event, but all qualified for the program, resulting in six enrollees.
- *SED sites in ethnic areas (some FFY 2000).*
  - A number of SED sites throughout the state are in areas with significant Hispanic populations and specialize in serving the needs of that community.
  - Three of our SED sites in metropolitan Denver are in neighborhoods with significant African-American populations.
  - Beginning in March 2000, CHP+ will initiate a poster campaign targeting metropolitan Denver neighborhoods with high percentages of Hispanic, African-American and Asian immigrant populations.
  - In spring 2000, CHP+ plans to pilot direct mail campaigns to metropolitan Denver neighborhoods with high percentages of Hispanic and African-American populations.
- *Ethnic celebrations.* CHP+ has staffed information booths at the annual Denver Juneteenth Celebration, targeting the African-American community.
- *Faith-related Outreach (for FFY 2000).*

- In October 1999, a CHP+ representative made a presentation to the Greater Denver Black Ministerial Alliance and provided information about CHP+ for distribution to area churches.
- In spring 2000, CHP+ plans to initiate outreach through the faith-based community, specifically targeting the African-American community.

- *Spanish-language applications*. CHP+ produces informational materials and applications in both Spanish and English.

3.4.5 Have any of the outreach activities been more successful in reaching certain populations? Which methods best reached which populations? How have you measured their effectiveness? Please present quantitative findings where available.

To date, Colorado's S-CHIP has not tracked response to individual outreach initiatives by ethnic group. We do know, however, that the best sources of overall referrals and enrollments on a consistent basis, thus far, have been:

- schools;
- social services offices;
- doctors' offices;
- friends/relatives;
- community health centers.

(Relative rank order of these sources has varied month by month, but the first five in the table below consistently remain among the five most common referral sources.)

New enrollees by referral type	Jul 99	Aug 99	Sep 99	Oct 99	Nov 99	Dec 99	YTD Average
Brochure	30	34	34	22	23	11	26
CHC	160	146	135	81	93	35	108
Doctor/Doctor's Office	161	196	167	164	118	73	147
Friend/Relative	116	139	113	134	94	56	109
Health Department	82	78	100	101	49	54	77
Newspaper	18	11	15	6	4	1	9
Poster	8	2	8	5	0	1	4
Radio	0	5	7	29	7	0	8
School	88	89	148	149	119	68	110
Social Services	291	323	340	304	221	44	254
Television	37	28	48	75	45	13	41
WIC	33	40	30	19	6	8	23

3.5 What other health programs are available to CHIP eligibles and how do you coordinate with them? (Section 2108(b)(1)(D))

Describe procedures to coordinate among CHIP programs, other health care programs, and non-health care programs. Table 3.5 identifies possible areas of coordination between CHIP and other programs (such as Medicaid, MCH, WIC, School Lunch). Check all areas in which coordination takes place and specify the nature of coordination in narrative text, either on the table or in an attachment.

Table 3.5

Type of coordination	**Medicaid***	**Maternal and child health, WIC program****	**Other (specify) School Lunch Programs*****	**Other (specify) Kids In Need of Dentistry (KIND)********
Administration	None	None	Inclusion of S-CHIP check-off box on FRM application	None
Outreach	DSS/DHS technicians invited to S-CHIP training sessions. Many technicians make S-CHIP information available and assist with application	WIC Educators invited to S-CHIP training sessions	Volunteers contact families about S-CHIP as a result of FRM application	Each program distributes the others' materials at events. KIND marketing committee discusses cross marketing.
Eligibility determination	Joint Medicaid/CHP+ application. Medicaid eligibility screen done before determining eligibility.	None	Same eligibility criteria (0-185% FPL). No eligibility by proxy.	Similar eligibility criteria, but no eligibility by proxy.
Service delivery	HCP	None	None	None
Procurement	Medicaid HMOs	None	None	None
Contracting	None	None	None	None
Data collection	None, though the state is considering this.	None	School officials gave FRM applications to S-CHIP due to Federal directive to share information	None
Quality assurance	None	None	None	None
Other (specify)				
Other (specify)				

Notes to Table 3.5:
* This column is not applicable for States with a Medicaid CHIP expansion program only.

** **WIC coordination with S-CHIP**. S-CHIP marketing staff invite WIC educators to S-CHIP information sessions to educate them on the program and to encourage them to make applications and information available to WIC clients.

*** **Free and Reduced Meal program coordination with S-CHIP**. For the 1999-2000 school year, the Free and Reduced school meal program (FRM) application featured an S-CHIP check-off box as a result of a Federal directive to encourage coordination between the FRM program and state S-CHIP programs. To protect families' rights of confidentiality, the application invited families to check off the information box if they were interested in receiving more information about the S-CHIP and Medicaid programs. When families checked the box, giving permission for their names to be released, school officials released this information to S-CHIP, and family information was entered into a database and assigned a tracking number.

[As of the end of January, 2000, S-CHIP had approximately 17,000 names entered into the FRM database and applications continue to arrive. Fifty-five (55) senior and federal employee volunteers assisted in mailing nearly 8,000 S-CHIP applications, making follow-up phone calls to approximately 1,000 families and attending approximately 20 back-to-school events to promote CHP+.]

Results to date:
- 7,830 applications sent out
- 376 completed applications received
- 84 children enrolled

CHP+ administration plan to again collaborate with **Colorado Department of Education** and Department of Agriculture representatives and school officials to develop new approaches to FRM outreach, with the goal of increasing effectiveness of this outreach tool for the 2000-2001 school year.

**** **KIND coordination with SCHIP**. A CHP+ representative is a member of the Kids In Need of Dentistry Marketing Committee. The committee discusses cross-marketing opportunities for various human service programs.

Colorado's Covering Kids Initiative and the Title V (MCH) program have assisted considerably as well in outreach efforts to potential S-CHIP enrollees. Volunteers from Covering Kids were involved in the school outreach campaign, and valuable, ongoing outreach is done through this organization at a variety of sites, which includes needed assistance with application completion and processing.

In addition, Colorado has made a concerted effort to closely coordinate the S-CHIP program with **Children and Families Medicaid programs**. This coordination occurs at all levels of program development and operations, ranging from policy development to eligibility determination. Colorado has made applying for CHP+ and Medicaid as seamless to the applicants as possible. The state S-CHIP program has adopted the state Medicaid program's minimal verification requirements to reduce administrative barriers to enrollment and establish similar requirements for both programs. Also, the

Colorado S-CHIP program and the Children and Families Medicaid programs have established a joint application.

Applications for children who seem eligible for Medicaid are forwarded from the eligibility determination contractor to the county Departments of Social Services (DSS). Conversely, applications that are determined ineligible for Medicaid by the DSS are forwarded to the state's S-CHIP eligibility determination contractor. In this model, eligibility determination technicians do not have to contact the client for additional information and, therefore, are able to enroll the child in Medicaid and S-CHIP more quickly. For the period from April 22, 1998 through September 30, 1999, there were 6,412 children forwarded to counties for Medicaid eligibility determination, and 3,875 forwarded by the counties for S-CHIP eligibility determination (*Note:* Referral sources were not tracked until July 1998, so are not available for April-June, 1998).

Still, the federal Medicaid-screening requirement for enrollment into the S-CHIP program is proving to be one of the most significant deterrents to enrolling certain populations, such as:

1) teens; 2) children from families that may not have a regular income source or may not be willing to share with a public program information about their income; 3) documented children from undocumented parents; and 4) people who have experienced problems with public programs in the past. *(See Attachment I: School-Based Outreach Report*, esp., Section III on Colorado.*)*

3.6 How do you avoid crowd-out of private insurance?

In the enabling legislation for the S-CHIP program, the Colorado General Assembly included measures to prevent crowd-out. In order for a child to be eligible to receive a subsidy for health insurance through the program, a child must not have, nor in the three months prior to application, been insured by a comparable health plan, if the employer contributes(ed) at least 50% of the premium. This provision does not apply if the child lost coverage due to a change in, or loss of, employment. There have been 436 applicants denied for having other insurance since July 1, 1998. This is an average of 3% of all denials.

3.6.1 Describe anti-crowd-out policies implemented by your CHIP program. If there are differences across programs, please describe for each program separately. Check all that apply and describe.

_X_ Eligibility determination process:

_X_ Waiting period without health insurance (specify)
3 months, if employer paid greater than 50% of the premium, unless there was a change in employment

_X_ Information on current or previous health insurance gathered on application (specify)
Self-reported questions on application regarding health insurance coverage

___ Information verified with employer (specify)

___ Records match (specify)
___ Other (specify)
___ Other (specify)

_X_ Benefit package design:

_X_ Benefit limits (specify)
20 outpatient visits and 45 inpatient days limit on non-neurobiologically-based mental illness; 20 outpatient visit limit for substance-abuse treatment; $2000 maximum per year for durable medical equipment; $800 maximum per year for hearing aids; 30 visit limit for any combination of physical, speech, or occupational therapies per diagnosis per year; all services (excluding preventive) must be medically necessary.

_X_ Cost-sharing (specify). (See chart below.)

	Level Monthly Payment for		Co-payment
	One Child	2 or More Children	
0%-100%	No Payment	No Payment	No Co-pay
101%-150%	$9 per family	$15 per family	$2
151%-170%	$15 per family	$25 per family	$5
171%-185%	$20 per family	$30 per family	$5

___ Other policies intended to avoid crowd out (e.g., insurance reform):

___ Other (specify)
___ Other (specify)

3.6.2 How do you monitor crowd-out? What have you found? Please attach any available reports or other documentation.

(See Sections 3.6 and 3.6.1.)

SECTION 4. PROGRAM ASSESSMENT

This section is designed to assess the effectiveness of your CHIP program(s), including enrollment, disenrollment, expenditures, access to care, and quality of care.

4.1 Who enrolled in your CHIP program?

4.1.1 What are the characteristics of children enrolled in your CHIP program? (Section 2108(b)(1)(B)(i))

Please complete Table 4.1.1 for each of your CHIP programs, based on data from your HCFA quarterly enrollment reports. Summarize the number of children enrolled and their characteristics. Also, discuss average length of enrollment (number of months) and how this varies by characteristics of children and families, as well as across programs.

States are also encouraged to provide additional tables on enrollment by other characteristics, including gender, race, ethnicity, parental employment status, parental marital status, urban/rural location, and immigrant status. Use the same format as Table 4.1.1, if possible.

Table 4.1.1 CHIP Program Type -- State Designed Program						
Characteristics	Number of children ever enrolled		Average number of months of enrollment		Year end enrollees as percentage of unduplicated enrollees per year	
	FFY 1998	FFY 1999	FFY 1998	FFY 1999	FFY 1998	FFY 1999
All Children	14,847	24,116	3.0	7.7	65.0%	80.8%
Age						
Under 1	338	1,851	1.4	3.0	67.8%	39.5%
1-5	4,341	7,212	3.0	7.6	66.2%	80.0%
6-12	6,210	9,547	3.1	8.1	65.6%	83.5%
13-18	3,958	5,506	3.1	8.9	62.8%	91.1%
Countable Income Level						
<101 % FPL	5,538	7,267	3.2	8.4	69.4%	76.4%
101-150 % FPL	5,610	9,732	3.0	7.5	64.0%	82.5%
151-171 % FPL	1,864	3,710	2.4	7.5	59.4%	84.2%
>171 % FPL	1,835	3,407	2.9	7.1	60.8%	81.7%
Age and Income						
Under 1						
<101 % FPL	86	434	1.6	2.7	81.4%	35.3%
101-150 % FPL	110	649	1.4	2.9	60.9%	39.1%
151-171 % FPL	73	415	1.3	3.1	65.8%	41.2%
>171 % FPL	69	353	1.4	3.3	60.9%	43.6%
1-5						
<101 % FPL	1,370	1,825	3.3	8.1	71.3%	74.6%
101-150 % FPL	1,546	2,745	3.0	7.3	65.6%	78.3%
151-171 % FPL	687	1,338	2.4	7.8	61.6%	87.8%
>171 % FPL	738	1,304	2.9	7.4	62.1%	82.9%
6-12						
<101 % FPL	2,126	2,629	3.3	8.7	70.6%	77.9%
101-150 % FPL	2,593	4,292	3.0	7.8	64.4%	85.4%
151-171 % FPL	782	1,409	2.6	8.0	60.0%	86.9%
>171 % FPL	709	1,217	3.0	7.5	61.2%	84.7%
13-18						
<101 % FPL	1,956	2,379	3.2	9.3	66.2%	83.5%
101-150 % FPL	1,361	2,046	3.2	8.6	61.7%	95.7%
151-171 % FPL	322	548	2.4	8.8	52.2%	100.9%
>171 % FPL	319	533	2.8	8.1	56.7%	97.4%
Type of plan						
Fee-for-service	0	0	-	-	-	-
Managed care	5,093	17,865	0.7	5.5	32.3%	83.9%
PCCM	9,754	6,251	4.2	14.0	82.1%	71.8%

a. Colorado began reporting enrollment data for its S-SCHIP program in Quarter three, FFY 1998; therefore, data for FFY 1998 are only partial year.

*Countable Income Level is as defined by the states for those that impose premiums at defined levels other than 150% FPL. See the HCFA Quarterly Report instructions for further details.

SOURCE: HCFA Quarterly Enrollment Reports, Forms HCFA-21E, HCFA-64.21E, HCFA-64EC, HCFA Statistical Information Management System, October 1998

[See Attachments J: CHP+ Enrollment by Ethnicity, Gender, Rural-Urban Categories, Immigrant Status, and Family Size]

4.1.2 How many CHIP enrollees had access to or coverage by health insurance prior to enrollment in CHIP? Please indicate the source of these data (e.g., application form, survey). (Section 2108(b)(1)(B)(i))

Colorado's S-CHIP program stipulates that the child cannot have had insurance up to three months prior to enrollment application. A question to this effect is on the application form, so information is self-report. Therefore, none of the enrollees can be said to have had access to insurance prior to enrollment in S-CHIP.

4.1.3 What is the effectiveness of other public and private programs in the State in increasing the availability of affordable quality individual and family health insurance for children? (Section 2108(b)(1)(C))

Pre-existing programs:

- Enrollment, benefit, policy and administrative information on Colorado Medicaid, CHP+ and CICP programs can be found on the Department of Health Care Policy and Financing's website, www.chcpf.state.co.us, on the Reference pages.

- The Colorado Medicaid program serves over 250,000 clients, excluding retroactivity; about half of those clients are children. Evaluation of the Medicaid program's effectiveness can be obtained from that program, administered by the Department of Health Care Policy and Financing's Office of Medical Assistance.

- The State-only Colorado Indigent Care Program (CICP) partially reimburses providers, primarily public hospitals and FQHCs, for care delivered to uninsured Coloradans of all ages. Over 160,000 clients were served in SFY 99 (July 1998-June 1999), for which providers received over $40 million in reimbursements.

- The CHP+ program coordinates closely with the Children With Special Needs (HCP) program, referenced above. This coordination allows CHP+ applicants access to the most comprehensive coverage available, and to coordinate appropriate "wrap-around" coverage for CHP+ enrollees.

- The State's Health Care Coverage Cooperative — The Alliance — offers choice of affordable coverage to small employers, including employer groups of one. Over 17,000 lives were covered by The Alliance in 1999; the proportion of children in that group is unknown.

- The Colorado Uninsurable Health Insurance Plan [CUHIP] provides State-subsidized access to commercial coverage for families with chronic health problems. Children in families whose income is higher than Medicaid, SSI and CHIP levels may be covered by CUHIP; however, fewer than 1000 lives are presently covered, a very small percentage of whom are children.

- FQHCs and Rural Health Clinic networks continue to provide the bulk of primary care for Medicaid, CHP+ and uninsured populations.

- Significant DSH funds support both FQHC and public hospitals, plus The Children's Hospital and a few private hospitals. These providers offer nearly Statewide access to emergency care, and substantial access to preventive/outpatient care, for children and adults, regardless of ability to pay.

- The State Medicaid and CHP+ programs are statutorily required to encourage participating HMOs to contract with "Essential Community Providers", in order to support the Safety Net's capacity to continue providing services to low-income and uninsured populations.

- Colorado Health Plan of the Rockies (CHPRS) and HCA are implementing a contract for both CHP+ and Medicaid which will target agencies for mental health services.

4.2 Who disenrolled from your CHIP program and why?

4.2.1 How many children disenrolled from your CHIP program(s)? Please discuss disenrollment rates presented in Table 4.1.1. Was disenrollment higher or lower than expected? How do CHIP disenrollment rates compare to traditional Medicaid disenrollment rates?

The Department defines disenrollees as those children who either terminated their coverage in the S-CHIP program before the anniversary date, or who failed to renew coverage at the anniversary date. Disenrollees do not re-new membership. Re-enrollees, on the other hand, are children whose coverage has terminated due to the anniversary date, or who allowed their coverage to lapse, and then re-entered the program within a short time.

Colorado's S-CHIP does not track disenrollees and non-re-enrollees separately in the database. They are tracked together as disenrollees. In FFY 1998, 1,106 children disenrolled or did not renew, and in FFY 1999, 5,344 children disenrolled or did not renew membership. In January 1999, the state began surveying families who disenrolled, or did not renew, about the reasons for their decision, and whether their children would have health insurance after leaving CHP+. Between January and September 1999, 1,989 families were surveyed. As of 1/6/00, 169 (8% of total disenrollees and 41.8% of those responding

to the survey) responded that their children would have health insurance from another source. This is based on a sample of 404 returned surveys, or a 20% response rate. By far, the most common reason given for disenrolling was that the family gained access to employment-based insurance.

Other reasons children disenroll before the end of their coverage period include: 1) turning 19; 2) financial or other reasons; and 3) moving out of state. The state is developing a system for tracking children who choose to disenroll before the end of their coverage period, as well as the reasons they give for their decision. The Department will be able to report on the disenrollees and non-renewals separately in future reports.

Two studies, recently released, also have examined reasons for disenrollment. *(See Attachments F, G, and P: Sundel Research, Inc. studies, and Dr. Allison Kempe's study, along with further discussion of these in Section 4.)*

Colorado is unable at this time to make comparisons between the State's CHP+ disenrollment rates and Medicaid disenrollment rates. Though the Medicaid program receives monthly summary reports on denials and disenrollments by reason, it is currently unable to tie disenrollment data back to specific individuals. With the fluctuating nature of Medicaid enrollments, there would be many duplicates among the reported disenrollees, so this total would be greatly inflated. By 2002, it is expected this tracking ability will be improved by the establishment of a new eligibility system, now in development.

4.2.2 How many children did not re-enroll at renewal? How many of the children who did not re-enroll got other coverage when they left CHIP?

As explained in Section 4.2.1 above, non-re-enrollees and disenrollees are tracked as one group. In FFY 1998, 1,106 children failed to re-enroll at their anniversary date. However, the Department at that time had not begun to track individual disenrollees and re-enrollees to know who they were and where they went. For FFY 1999, the total was 5,344 children. Of these, 1,989 were sent surveys requesting information on reasons for disenrollment and coverage status following CHP+. Only 404 returned the surveys; of those, 169 reported having other insurance. This is approximately 42% of the sample of respondents.

4.2.3 What were the reasons for discontinuation of coverage under CHIP? (Please specify data source, methodologies, and reporting period.)

(Due to low response rate, the results reported in the following table should be considered with caution.)

Table 4.2.3

Reason for discontinuation of coverage	Medicaid CHIP Expansion Program		State-designed CHIP Program			
	Number of disenrollees	Percent of total	Number of disenrollees	Percent of disenrollees surveyed	Percent of disenrollees responding	Percent of disenrollees who do not plan to renew
Total			FFY98 -1,106* FFY99 - 5,344	FFY98 – N/a FFY99=1,989	FFY98 – N/a FFY99=404	FFY98 – N/a FFY99=219
Access to commercial insurance			151	8%	37%	69%
Eligible for Medicaid**			27	1%	7%	12%
Income too high			24	1%	6%	11%
Aged out of program			6	<1%	1%	3%
Moved/died			27	1%	7%	12%
Nonpayment of premium***			7	<1%	1%	3%
Incomplete documentation			N/a	N/a	N/a	N/a
Did not reply/unable to contact			1597	80%	N/a	N/a
Other (specify) Dissatisfied with services/program			10	<1%	2%	5%
Other (specify) Application too difficult/paperwork too difficult to gather			6	<1%	1%	3%
Don't know			N/a	N/a	N/a	N/a

* Disenrollment Reasons were not tracked in FFY 1998, so all reasons are for FFY 1999 only.

** Respondents who *said they enrolled their children in Medicaid*; others were probably *eligible*, including some who may have moved.

*** Respondents who reported they were unable to pay premiums; *no one was disenrolled for failure to pay premiums.*

4.2.4 What steps is your State taking to ensure that children who disenroll, but are still eligible, re-enroll?

CHP+ members receive a renewal application and reminder letter 60 days prior to their termination date. The renewal notification explains in detail what documents and sections of the application need to be complete. Additionally, the letter provides a deadline for submission of the renewal application to allow for continuous coverage. If the renewal application is not returned by the deadline, a reminder letter is sent.

4.3 How much did you spend on your CHIP program?

4.3.1 What were the total expenditures for your CHIP program in federal fiscal year (FFY) 1998 and 1999?

FFY 1998 ___$1,339,561_____

FFY 1999 __$12, 521,710_____

Please complete Table 4.3.1 for each of your CHIP programs and summarize expenditures by category (total computable expenditures and federal share). What proportion was spent on purchasing private health insurance premiums versus purchasing direct services?

***The data reported in this table reflect an agreement between the Department and the regional HCFA office on reporting data in the form that was available. This is consistent with the quarterly reporting on expenditures to HCFA.**

Table 4.3.1* CHIP Program Type _State-Designed Program_____

Type of expenditure	Total computable share		Total federal share	
	FFY 1998	FFY 1999	FFY 1998	FFY 1999
Total expenditures	$1,339,561	$12,521,710	$ 889,200	$8,191,702
Premiums for private health insurance (net of cost-sharing offsets)*	1,339,561	12,305,898	889,200	8,050,518
Departmental-operated managed care system expenditures (subtotal)	0	215,812		141,184
Inpatient hospital services				
Inpatient mental health facility services				
Nursing care services				
Physician and surgical services	0	215,812		141,184
Outpatient hospital services				
Outpatient mental health facility services				
Prescribed drugs				
Dental services				
Vision services				
Other practitioners' services				
Clinic services				
Therapy and rehabilitation services				

Laboratory and radiological services				
Durable and disposable medical equipment				
Family planning				
Abortions				
Screening services				
Home health				
Home and community-based services				
Hospice				
Medical transportation				
Case management				
Other services				

4.3.2 What were the total expenditures that applied to the 10 percent limit? Please complete Table 4.3.2 and summarize expenditures by category.

What types of activities were funded under the 10 percent cap?

- Marketing and Outreach
- All aspects of Administration

What role did the 10 percent cap have in program design? _____

The 10% cap places severe strictures on design, development and growth of the S-CHIP Program, limiting its ability to do outreach and to design up-front systems which can streamline eligibility. While the cap may be reasonable for mature programs, it does not allow states sufficient funding for effective program start-up.

Some specific S-CHIP design and implementation factors affected by the 10% limit include:

- The Federal definition of marketing and outreach, which designates administrative costs as subject to the 10% limit, means that S-CHIP marketing and outreach efforts are severely restricted. For a new program/product, extensive marketing is essential to gaining name recognition, to educating potential consumers to the availability and value of the product, and creating demand for it. For these reasons, marketing and, for social programs, outreach are generally recognized as separate costs for administration. Mass media purchases, and reimbursement to local community agencies for covering outreach and enrollment assistance costs, are two examples of under-funded activities.
- The 10% FFP cap has not recognized legitimate start-up costs such as program design and development, information systems development (including software and hardware), office space acquisition/modifications, and equipment.
- HCFA's has recently provided us with an interpretation that network/benefit management costs are health care costs, when provided by an HMO, but program administration costs (subject to the 10% FFP cap), when contracted by the State. The State has submitted documentation to HCFA on this issue and will continue to review the implications of this determination.

Table 4.3.2						
Type of expenditure	Medicaid Chip Expansion Program		State-designed CHIP Program		Other CHIP Program* _____	
	FY 1998	FY 1999	FY 1998	FY 1999	FY 1998	FY 1999
Total computable share			$148,840	1,291,301		
Outreach			61,021	667,746		
Administration			87,819	623,555		
Other_____						
Federal share			98,799	844,768		
Outreach			40,505	436,839		
Administration			58,294	407,929		
Other ___						

4.3.3 What were the non-Federal sources of funds spent on your CHIP program (Section 2108(b)(1)(B)(vii))

_X_ State appropriations
_X_ County/local funds
___ Employer contributions
_X_ Foundation grants
_X_ Private donations (such as United Way, sponsorship)
___ Other (specify) _____

4.4 How are you assuring CHIP enrollees have access to care?

4.4.1 What processes are being used to monitor and evaluate access to care received by CHIP enrollees? Please specify each delivery system used (from question 3.2.3) if approaches vary by the delivery system within each program. For example, if an approach is used in managed care, specify 'MCO.' If an approach is used in Departmental-operated managed care system, specify 'FFS.' If an approach is used in a Primary Care Case Management program, specify 'PCCM.'

Table 4.4.1

Approaches to monitoring access	Medicaid CHIP Expansion Program	State-designed CHIP Program	Other CHIP Program* _____
Appointment audits			
PCP/enrollee ratios			
Time/distance standards			
Urgent/routine care access standards			
Network capacity reviews (rural providers, safety net providers, specialty mix)		MCO, developing for state system	
Complaint/grievance/ Disenrollment reviews		MCO, state system	
Case file reviews			
Beneficiary surveys		Planned for MCO & state system	
Utilization analysis (emergency room use, preventive care use)		Planned for MCO & state system	
Other (specify) _____			

4.4.2 What kind of managed care utilization data are you collecting for each of your CHIP programs? If your State has no contracts with health plans, skip to section.

Table 4.4.2

Type of utilization data	Medicaid CHIP Expansion Program	State-designed CHIP Program	Other CHIP Program* _____
Requiring submission of raw encounter data by health plans	___ Yes ___ No	_X_ Yes* ___ No	___ Yes ___ No
Requiring submission of aggregate HEDIS data by health plans	___ Yes ___ No	_X_ Yes * ___ No	___ Yes ___ No
Other (specify)_____	___ Yes ___ No	___ Yes ___ No	___ Yes ___ No

*Colorado is not currently collecting utilization data, but is planning to do so *(See Attachment C: Quality Improvement Goals)*.

4.4.3 What information (if any) is currently available on access to care by CHIP enrollees in your State? Please summarize the results.

Colorado is not currently collecting utilization data, but is planning to do so *(See Attachment C: Quality Improvement Goals)*.

4.4.4 What plans does your CHIP program have for future monitoring/evaluation of access to care by CHIP enrollees? When will data be available?

Colorado is not currently collecting utilization data, but is planning to do so *(See Attachment C: Quality Improvement Goals)*.

4.5 How are you measuring the quality of care received by CHIP enrollees?

4.5.1 What processes are you using to monitor and evaluate quality of care received by CHIP enrollees, particularly with respect to well-baby care, well-child care, and immunizations? Please specify the approaches used to monitor quality within each delivery system (from question 3.2.3). For example, if an approach is used in managed care, specify 'MCO.' If an approach is used in Departmental-operated managed care system, specify 'FFS.' If an approach is used in primary care case management, specify 'PCCM.'

Table 4.5.1

Approaches to monitoring quality	Medicaid CHIP Expansion Program	State-designed CHIP Program	Other CHIP Program
Focused studies (specify)			
Client satisfaction surveys		Planned*	
Complaint/grievance/ Disenrollment reviews		X	
Sentinel event reviews			
Plan site visits			
Case file reviews			
Independent peer review			
HEDIS performance measurement		Planned	
Other performance measurement (specify)			
Other (specify) _____			
Other (specify) _____			
Other (specify) _____			

- The disenrollment and re-enrollment survey results (see attached Sundel Research and Kempe studies) address client satisfaction very briefly (*See Attachments F, G, and L.*).

4.5.2 What information (if any) is currently available on quality of care received by CHIP enrollees in your State? Please summarize the results.

(See Section 4.5.3.)

4.5.3 What plans does your CHIP program have for future monitoring/evaluation of quality of care received by CHIP enrollees? When will data be available?

(See Table 1.3, Performance Measures and Progress for Strategic Objective #4).

4.6 Please attach any reports or other documents addressing access, quality, utilization, costs, satisfaction, or other aspects of your CHIP program's performance. Please list attachments here.

LIST OF ATTACHMENTS FOR THE MARCH 2000 EVALUATION REPORT

Attachment A:	Enrollment in Health Maintenance Organizations
Attachment B:	Service Delivery Table
Attachment C:	Quality Improvement Goals
Attachment D:	White Paper -- "Establishing a Colorado Health Insurance Employer Buy-In for Kids: Issues and Options"
Attachment E:	Colorado Community Health Network Outreach Project Study -- CHP+ Survey
Attachment F:	Sundel Research, Inc. -- Colorado Child Health Plan Plus Dis-Enrollee Study
Attachment G:	Sundel Research, Inc. -- Colorado Child Health Plan Plus Re-Enrollee Study
Attachment H:	Study on Premium Affordability -- "Prices and Affordability of Health Insurance for Colorado's Uninsured Population," (Draft) -- Judy Glazner
Attachment I:	School-Based Outreach Report
Attachment J:	Colorado CHP+ Enrollment by Ethnicity, Gender, Rural/Urban Category, Immigrant Status, and Family Size, September 1999
Attachment K:	Survey on Dis-enrollees -- Child Health Advocates'
Attachment L:	Study on CHP+ Application Non-Submittals -- Dr. Allison Kempe
Attachment M:	Summary of Evaluation Studies Focusing on Colorado's CHP+ Program
Attachment N:	CBHP/CHP+ Administrative Structure @ 9/99
Attachment O:	CHP+, Medicaid, CICP Application Redesign Initiative Update, January 2000
Attachment P:	Report on Administrative Structure of the CHP+ Program, State of Colorado, October 1999, by RK Associates

SECTION 5. REFLECTIONS

This section is designed to identify lessons learned by the State during the early implementation of its CHIP program as well as to discuss ways in which the State plans to improve its CHIP program in the future. The State evaluation should conclude with recommendations of how the Title XXI program could be improved.

5.1 What worked and what didn't work when designing and implementing your CHIP program? What lessons have you learned? What are your "best practices"? Where possible, describe what evaluation efforts have been completed, are underway, or planned to analyze what worked and what didn't work. Be as specific and detailed as possible. (Answer all that apply. Enter 'NA' for not applicable.)

Lessons Learned:

5.1.1 Eligibility Determination/Redetermination and Enrollment

- **It is not easier to modify an existing program than to start from scratch.** Colorado modified the previous Colorado Child Health Plan to create the Child Health Plan Plus. Existing eligibility determination processes were modified to accommodate the new federal requirements. Getting community partners to buy in to new policies and procedures was difficult when the old system of determining eligibility was perceived to work well.
- **Coordinating a new program with a well-established Medicaid program is challenging, but do-able and rewarding**. County departments of social services (DSS) determine eligibility for Medicaid. There have been varying degrees of participation by the counties, such as: 1) forwarding applications that are not Medicaid eligible for CHP+ determination; 2) responding to requests for information about results of Medicaid eligibility determination from referrals; and 3) accepting the validity of the CHP+ Medicaid screen.
- **When all community partners buy in to the process, you can get amazing results.**
- **What works in one state does not guarantee that the same process will work in another**. Demographics vary from state to state, as does program design and legislation. Typically what makes a process work is the commitment of the individuals involved in implementing the process. However, sharing best practices nationally would help states identify program models that might be adapted for local needs.

5.1.2 Outreach

- **Don't expect success overnight**. Even with the base of an existing program, progress is slow.
- **Prioritize clearly** so that everyone, including partners, understands his/her role and responsibilities. With enrollment targets and clearly defined strategies, the public can judge more easily where the program stands and what it is expected to accomplish.
- **Do coordinate effectively with partners**, with regular and open communication, so that everyone is moving in the same direction.

5.1.3 Benefit Structure

- **The benefit structure has seemed to meet the needs of its members.** Evaluation will have to occur over time. The major deficiency in the benefit design is the lack of a dental benefit.

5.1.4 Cost-Sharing (such as premiums, copayments, compliance with 5% cap)

- **There is conflicting research on the impact of premiums** *(See Appendices F, G, K, and L: Sundel, Child Health Advocates, and Kempe studies).*
- Recent studies have indicated that **families may not have any additional disposable income to pay for premiums** *(See Appendix H: Prices and Affordability of Insurance for Colorado's Uninsured Population").*
- **What is missing is definitive research** locally or nationally on the appropriate level of premiums by income level (100-150% FPL; 151-200% FPL; 200%+FPL), and the impact of administrative systems (e.g., paying monthly or quarterly).

5.1.5 Delivery System

- **Colorado would like to be able to offer S-CHIP solely through managed care organizations. This has not proved possible due to lack of coverage in some areas of the state**. Therefore, the state has had to maintain its own network for a large portion of rural enrollees, which has proved to be administratively burdensome.

HCFA's narrow interpretation of health care cost adds a further burden on the many midwestern and western states with large rural areas facing health manpower shortages. The Department of Health Care Policy and Financing contracts with six (6) health maintenance organizations on a full risk basis to deliver benefits available under the Colorado CHP+ program. However, HMO coverage is not available in many rural areas and other communities where managed care has not been established. Thus, the Department maintains numerous direct contracts with providers using a managed-care model, including a primary care capitation to ensure delivery of benefits to children statewide.

The Department enjoys substantial fee discounts and management rights (e.g., gatekeeper arrangements, pre-certification and referral authorization requirements, etc.)

in these provider contracts that are typically not available in comparable, statewide, PPO-type networks. The existence of these unique provider contracts is largely attributable to the network development efforts undertaken by prominent pediatricians within the University/Children's hospital system over a period of several years, and a reservoir of good will within provider communities throughout the State.

Delivery of benefits via the state network has proven cost-effective to date (at least in comparison to other existing options), given the current level of enrollment. Lacking an appropriation for the claims-variation reserves maintained by most insurers and self-insured groups, the Department is uncomfortable with long-term responsibility for direct management of financial risk. Several insurers, including those participating in the program, have expressed an interest assuming risk from the Department at the current HMO rates. However, these proposals have all been contingent upon receipt or exclusive use of the Department's network by the insurer.

The Department will therefore continue to explore any options that may be possible for obtaining cost-effective, statewide coverage on a full-risk basis.

5.1.6 Coordination with Other Programs (especially private insurance and crowd-out)

Medicaid

- **Cooperation occurs when all parties have a vested interest in the outcome**, and when they participate in an open environment where their input is respected and valued. Colorado is a state in which stakeholders routinely cooperate on difficult social policy issues to create meaningful change. The S-CHIP evolved from a community-based planning effort. This has continued and been formalized in a Policy Board representing four state agencies, business, providers, and consumers.
- While Colorado cooperates in outreach activities with other agencies serving children (WIC, School Free/Reduced Price Lunch, etc.), **actual enrollment functions are hindered by the Medicaid screening requirement**.

Private Insurance

- **Colorado is considering options for coordination with other insurers and/or employers to enroll more eligible children of working parents**. However, at this early stage we have identified issues with the proposed federal regulations which may preclude us from pursuing this option (*See Attachment D: "Establishing a Colorado Health Insurance Employer Buy-In for Kids: Issues and Options").*

5.1.7 Evaluation and Monitoring (including data reporting)

- **Effective evaluation and monitoring require regular and consistent community-wide coordination** with experts in health care and evaluation, to insure results that focus on issues that are relevant to the State's program.
- **Evaluation of a program that is still relatively new nationally entails**:
  - frequent **communication** with other states

- **sharing of results of studies and program successes**
- **intentional focus on the uniqueness** of the State's own program (solutions are not one-size-fits-all), as well as attention to commonalities with other states

- **Success of Evaluation efforts** in Colorado have depended on:
  - **attention to** federal/state reporting requirements, and program design;
  - **identification of issues** that lead to useful policymaking support and accurate reflection of growth areas in the program;
  - **regular, clear communication** with persons involved in information-gathering and reporting;
  - **vigilant monitoring** of data accuracy
  - **persevering in the effort** to make it better.
- **Colorado's Evaluation efforts are continuous**, as new issues emerge from the legislature, the public, and within the Department on how to provide appropriate health care coverage to all the State's children.

5.1.8 Other (specify)

Privatized administration:
Pursuant to State statute requiring "maximized privatization of CBHP administration," Colorado contracts over 90% of its S-CHIP administration to private sector contractors. *(See Attachment R: CBHP/CHP+ Administrative Structure @9/99)*. The Policy Board, appointed by the Governor, consists of executive directors of the Departments of Public Health and Environment, Education, Health Care Policy and Financing, and Human Services, as well as members from the business community, the health care industry, an essential community provider, and a consumer. The Board has rule-making authority and provides administrative direction for the program. The State's current major contractor for Eligibility and Enrollment, Marketing and Outreach, Premium Administration and Network Administration employs about 70 staff. Observations on this structure would include:

- **Regular communication between Department staff and contractors ensures success.**
- **Consistent and Regular Contract Management is required**. This is especially true when a new program is being implemented and operated at the same time that it is being designed and developed.

Best Practices:

5.1.1 Eligibility Determination/Re-determination and Enrollment

- **Colorado uses a joint application**. While the application is being redesigned to make it more attractive to applicants, the use of a joint application ensures that eligibility can be determined for the appropriate program without additional contact with the applicant.
- **Colorado has made the documentation requirements for CHP+ and Medicaid as consistent as possible**. This guarantees that the information

needed to determine eligibility for both programs is included, no matter where the application originates.

- The Department has **developed and implemented an eligibility, enrollment and application tracking system** for the Children's Basic Health Plan. The system was designed to utilize a **sophisticated business rules engine** and state-of-the-art **secure Internet technologies** to:
  - **reduce the overall cost** of administration;
  - **increase the speed and accuracy** of screening for eligibility for Medicaid;
  - **determine eligibility** for the Children's Basic Health Plan;
  - **enroll** children into the program.

5.1.2 Outreach

- **Use volunteers where appropriate**. Federal Employees manning Back-to-School follow-up was a very successful effort for increasing manpower and decreasing costs. However, not every job can be manned by a volunteer.
- **Clearly delineate expectations**. When partners know what is expected, they can perform or ask for assistance where needed.
- **Track and record not only visibility, but also enrollments.** Often we received good feedback on visibility from the phone lines and the application form; we are still learning ways to identify our marketing and outreach gaps in actual enrollments.

5.1.3 Benefit Structure

- The Benefit Structure for Colorado's S-CHIP was designed through a **committee process allowing input from community-wide sources**. It was designed, in part, to mirror the employer market, assisting families as they transition into the workforce. This structure should also be helpful when implementing an employer buy-in product for S-CHIP.

5.1.4 Cost-Sharing (such as premiums, copayments, compliance with 5% cap)

- Though the studies referenced under "Lessons Learned" on the issue of premiums asked only a few brief questions *about* premiums, efforts are now underway in Colorado to study, more directly and comprehensively, premium issues as they relate to Colorado's CHP+ population. This is being done in **collaboration with external evaluators specializing in this area**.

5.1.5 Delivery System

- **The State has developed a managed care network** where previously there was no risk-based managed care available.
- **Colorado continues to look for new and innovative ways to provide coverage** in a cost-effective manner for all children in Colorado.

5.1.6 Coordination with Other Programs (especially private insurance and crowd-out)

Title V

- In Colorado, S-CHIP works closely with the Title V program, the Health Care

Program for Children with Special Needs (HCP), to identify enrollees with special needs. This collaboration has worked well in assisting families to receive services available in their communities. Colorado has recently received a grant from the Robert-Wood Johnson Foundation to implement replicable systems to improve care coordination for children with special needs in S-CHIP HMOs.

- Colorado has just received a grant from the Center for Health Care Strategies, Inc. and the Rose Community Foundation to implement the **Children's Comprehensive Care (CCC) Project**. The CCC Project aims to **improve care coordination, linkages with community-based organizations, and child and parent education for children with chronic conditions and special needs** in Temporary Assistance for Needy Families (TANF)/Medicaid and Child Health Plan Plus (CHP+) Health Maintenance Organizations (HMOs).

Colorado Covering Kids Initiative

- **The Covering Kids Initiative in Colorado brings together the efforts** of health care providers, children's advocacy groups, family leaders, private foundations, business advisers, and state agencies to enroll Colorado's uninsured children in programs for which they are eligible (Medicaid, S-CHIP, and other health coverage programs targeting low-income, uninsured children).
- **Covering Kids organizes outreach training** in communities around Colorado, consolidates application processes at specific sites, and helps to coordinate evaluation to improve program operation.
- Efforts have been **particularly fruitful in Prowers County**, one of Colorado's southeast, rural counties, where they have been able to get nearly all of the county's S-CHIP-eligibles enrolled. **The Prowers County experience demonstrates that a community can impact insurance and health status of its residents when there is a coordinated effort of all community organizations.**
- The State has worked with Covering Kids and other organizations to sponsor the **Children's Health Summit**, events held across the region over several months time, bringing together providers, policymakers, faith-based groups, and social service agencies.

CUHIP

- Colorado is beginning to explore a relationship with the Colorado Uninsurable Health Insurance Plan. This is a state risk pool designed for persons who do not have access to health insurance due to health status, or have access to insurance but find that coverage is unaffordable.

Medicaid

- Colorado has developed a **joint application and integrated processes** for S-CHIP and Medicaid.
- Medicaid and S-CHIP personnel sit on **key policy and administrative committees** to:
  - Develop outreach strategies with FQHCs;
  - Coordinate eligibility criteria, rules, and procedures;

- Share data;
- Streamline enrollment processes;
- In community, establish best practices with key stakeholders;
- Pilot an integrated, automated eligibility system;
- Problem-solve

5.1.7 Evaluation and Monitoring (including data reporting)

- **Frequent and regular communications on program strengths through:**
  - **Departmental participation on, and coordination with, community-wide committees** focused on healthcare issues and evaluation *(See Appendix M: Summary of Evaluation Studies Focusing on Colorado's CHP+ Program").*
  - **Regular reporting to the Legislature, the Policy Board, and other stakeholders**
- **Colorado has made it a point to become informed on the unique characteristics of its target population**. For example, the State has a significant Hispanic population that may require specifically focused marketing and outreach strategies. In addition, the targeted income group (at or below 185% FPL) may be a population unaccustomed to monthly budgeting for healthcare. This has prompted the State to investigate other potential premium structures.
- Colorado focuses on **evaluation issues that will provide program direction and growth,** in a rapidly changing environment.
- The State has put in place **data systems that produce data valuable to program monitoring.**

5.1.6 Other (Specify)

Rules

- The program is in the early stages of the rule-making process, with one rule passed and three additional ones at various stages of the process. To meet the challenges of the rule-making process, the Department has put a great deal of effort into the creation of schedules and **dissemination of information as early as possible to all stakeholders**.
- This **communication has been crucial** to the Department's ability to meet administrative requirements and be responsive to public input.

Stakeholder Input

- Colorado has developed and implemented a **public input process** to enhance policymaking for successful program direction.

5.2 What plans does your State have for "improving the availability of health insurance and health care for children"? (Section 2108(b)(1)(F))

- **Marketing and Outreach Plan**. Colorado has an **extensive strategic planning document in place.** Throughout the spring, we will be **revising this plan to accommodate**

the lessons we have learned and focus our **attention on the most successful efforts,** both in Colorado and around the nation. In general, it is our intention to:

- maintain our **community-based outreach approach**
- significantly revise our **school-based outreach**
- develop an **employer-based pilot project** over the next year to offer eligible families who are not a part of the social safety net the choice of S-CHIP.

- **Alternative Policies for Making Healthcare Coverage More Widespread.**
  - The State is considering the **implications of raising the upper income limit from 185% FPL to 200% FPL,** for both the S-CHIP and CICP programs.
  - The State has recently **redesigned its application to facilitate three-way eligibility determination** for potential S-CHIP, Medicaid, and CICP enrollees. This is expected to simplify the application process and make it easier and more appealing for families. The new application will be field-tested in April, 2000 *(See Attachment O: CHP+, Medicaid, CICP Application Redesign Initiative Update, January 2000).*
  - The State is investigating **alternative premium structures**, and is active in collaborating on, and helping to facilitate, **research on the premium issue to determine the barriers it presents** for the under 200% FPL group. The **most recent, unprecedented study** on the issue of premium affordability among the general population is: Prices and Affordability of Health Insurance for Colorado's Uninsured Population (Draft), by Judy Glazner, February 2000 *(See Attachment H).* Negotiations are underway to initiate further study that focuses on questions more directly related to the S-CHIP population.

- **Advocacy groups**, including
  - the MCH/public health,
  - Colorado Covering Kids Initiative,
  - Coalition for the Medically Underserved,
  - the Colorado Children's Campaign,
  - the Rose Community Foundation,
  - the American Academy of Pediatrics,
  - La Rasa,
  - the Colorado Trust,
  - Denver Health, and
  - the Colorado Community Health Network,

  continue to be instrumental in identifying and quantifying needs, and in proposing and supporting solutions. Robert Wood Johnson, the Kellogg Foundation, and the Rose Community Foundation have provided substantial financial and advisory support to Colorado's efforts in these directions.

5.2 What recommendations does your State have for improving the Title XXI program? (Section 2108(b)(1)(G))

- **The 10% cap places severe strictures on design, development and growth of the**

CHIP program. While the 10% cap may ultimately be a reasonable level for mature programs, it does not allow states sufficient funding for effective program start-up.

- **Better coordination is needed from the Federal players:** Often agencies would produce useful tools or missives and the Department would be the last to know about them (e.g., Dept. of Ed. Back-to-School letters, United Way/Justice Dept. project, ads on local TV stations).

- **Fix the National School Lunch Program confidentiality issues at the Federal level** to give Title XXI programs more leverage.

- **It would be most helpful to states if HHS provided a clearinghouse for state-based information and activities** that clearly shows best practices, successes, and elements thereof, either through NGA or other resources.

- **Web-based, term-searchable centralization of HCFA central and regional office approvals** would assist states considerably, not only in designing and modifying state plans, but in state-based practices, so that once something is approved somewhere in the US, everyone can utilize that clearance. No one has to re-invent the approval process. This could reduce regional disparities and increase collaboration and cooperation.

* * *

The Department is optimistic about the future of its S-CHIP program, known as Child Health Plan Plus, or CHP+. In its first 17+ months of operation, it expanded over four-fold from an initial rollover enrollment of more than 5,000 children. The program continues to grow rapidly and to receive positive feedback from families enrolled in the program, who feel good about their ability to provide affordable commercial-like health insurance coverage for their children. Families who disenroll their children generally do so because they have gained access to other health insurance. This is further reflection of the success of the program in helping families to transition into the managed care environment.

Colorado is mindful of its goals for providing coverage to the remaining uninsured and is successfully finding ways to reach out to families, with strategies that take into account the special characteristics of this 185%-FPL-and-below income group. With continued coordination with many enthusiastic community partners, Colorado's S-CHIP program is succeeding in realizing its goals.